

Hospital: _____

CLAIM SERVICES REFERRAL FORM

Requestor's Name: _____ Phone/Ext: _____

Fax #: _____

Patient Name: _____

Account Number: _____ Date of Request: _____

Total Charges: _____ Date of Service: _____ to _____

Please check box below for form(s) needed:

Accident Details	<input type="checkbox"/>	Lien Information	<input type="checkbox"/>	Police Report	<input type="checkbox"/>
Add Baby to Policy	<input type="checkbox"/>	Marriage Certificate	<input type="checkbox"/>	Pre-existing Questionnaire	<input type="checkbox"/>
Birth Certificate	<input type="checkbox"/>	Medicare Liability Form	<input type="checkbox"/>	Authorization for Release of Medical Records	<input type="checkbox"/>
Claim Form	<input type="checkbox"/>	Medicare Questionnaire	<input type="checkbox"/>	Student Status	<input type="checkbox"/>
COBRA Application	<input type="checkbox"/>	Non-Availability Statement	<input type="checkbox"/>	Subrogation Form	<input type="checkbox"/>
COB	<input type="checkbox"/>	PCP Referral	<input type="checkbox"/>	Update Common Working File	<input type="checkbox"/>
Death Certificate	<input type="checkbox"/>		<input type="checkbox"/>	Other (please provide additional information below)	<input type="checkbox"/>

Please include the following: Face Sheet
Patient/Guarantor Demographics
Insurance Information
POE Information (if available)
Pertinent Notes
Death Indicator

Other: _____

Fax or email to: Fax: 800-721-4033
Email: JudyL@claimservices.org

For account status, email: JudyL@claimservices.org

Toll free phone: 800-939-6997

Notes: _____
