Blount Memorial Hospital

Business Office

INSURANCE BILLING INFORMATION

ACCOUNT/CYCLE #: _____ PATIENT NAME:_____

Insurance Co Name: _____

Claim Mailing Address: _____

SUBSCRIBER NAME: _____ Subscriber DOB: _____

Patient Relationship to Subscriber: _____

ID#: _____ GR #: _____ Effective date:_____

Subscriber's Employer: _____

Employer Address: _____

Employer Phone #: ( ) _____ Benefits Rep: _____

Subscriber Employment Status: _____ Full Time _____ Part Time ____ Other (explain): _____

MSP Form Completed: ____ Yes ____ No – Why Not?_____

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LIABILITY INSURANCE FOR PERSONAL INJURY / ACCIDENT/ WORK RELATED INJURY:

Date of Accident: _____ Time: _____ Place: _____

Auto Claim Filing Date: _____ WC Date of First Report of Injury: _____

Policy Holder or Employer: _____

Employer Address: _____

Insurance Co Name: _____

Claim Mailing Address: _____

_____

CLAIM #: _____ POLICY #: _____

Claim Adjustor: _____ Adjustor Phone #: ( )_____

Will patient complete a Letter of Assignment: _____ Date Mailed: _____

If no, why not?: _____

MED Pay Amount: $ _____