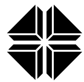

Blount Memorial Hospital

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? ____

==

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: $ ______________________________