Supporting Documentation – Standard Cover Sheet

Health Plan: _____ **Product:** _____

Attention: _____

Date Cover Sheet Prepared: _____

♦ **Use ONE cover sheet per submitted claim & DO NOT attach a copy of the claim. DO NOT use for a corrected claim OR request for review.** ♦

Original Claim Number (from voucher)**:** _____ ☐ Check here if claim was submitted electronically

Claim Identification Information:

Patient First Name: _____ MI: _____ Last: _____

Patient Date of Birth: __ __ __ __ __ __ __ __ Date(s) of Service: _____

Provider of Service: _____ Tax ID#: _____

Subscriber/Member ID# with prefix (when appropriate): _____

Subscriber's First Name: _____ MI: _____ Last: _____

Provider Office Contact Person:

Name: _____ Phone Number: _____

Other information: _____

Comments (Optional):

List of the documentation you attached: