Health Plan:	Product:		
Attention: Date Cover Sheet			
♦ Use ONE cover sheet per submitted claim & <u>DO NOT</u> attach a copy of the claim. ♦ <u>DO NOT</u> use for a corrected claim OR request for review.			
Original Claim Number (from voucher):		o	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:			

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