1. Health insurance Coverage Medicare ☐ Medicaid ☐ Group plan ☐ Other ☐	2. Patient relationship to insured Self ☐ Spouse ☐ Child ☐ Other ☐	3. Insured's ID Number
4. Patient's Name	5. Patient Birth date	6. Insured's Birth Date
7. Street Address	8. City	9. State
10. Zip Code	11. Telephone	12. Alternate Telephone

13. Is Patient's Condition Related to:

a. Employment	b. Auto Accident	c. Other Accident
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

14. Diagnosis or nature of illness or injury

a.	b.	c.	d.
e.	f.	g.	h.
i.	j.	k.	l.

15. Claims

	Dates of Service FROM			TO			Procedure, service or supplies Description	CPT/HCPCS	Charges	Amount Paid
a.										
b.										
c.										
d.										
e.										
f.										
g.										

16. Total Charges	17. Amount Paid	18. Amount Due