|  |
| --- |
| **{insurance}** |
| **MEDICAL CLAIMS DEPARTAMENT** |
|  |
|  |
|  |
| **X {ssn}** |
| **{patientName} {dob} X {insuranceHolder}** |
| **{addressPatient} X {addressHolder}** |
| **{city} {state} {cityHolder} {stateHolder}** |
| **{zip} {phoneNumber} {zipHolder} {phoneNumberHolder}** |
|  |
| **X {dob} X** |
| **X {state}** |
| **X {insurance}** |
| **X** |
| **SIGNATURE ON FILE {dateReceipt} SIGNATURE ON FILE** |
| **{accidentDate}** |
|  |
| **DR ALAN KHIGER 1336452671** |
|  |
| **{firstRemain} X**  **0** |
| **{dai\_0\_0} {dai\_0\_3} {dai\_0\_6} {dai\_0\_9}** |
| **{dai\_0\_1} {dai\_0\_4} {dai\_0\_7} {dai\_0\_10}** |
| **{dai\_0\_2} {dai\_0\_5} {dai\_0\_8} {dai\_0\_11}** |
|  |
|  |
| **{#firstServices}{0} {0} 11 {label} ABCD {value}.00 1 {npi\_0}** |
| **{/firstServices}** |