



Creating solutions, One person at a time

Health Insurance Information Referral Form

(Please Print)

Consumer Name: _____

CI Client No: _____ Date of Birth: _____

Health Ins. Co. Name (1) _____ Policy No. _____
(2) _____ Policy No. _____

Reason for Referral

- 1. _____ Consumer was never covered by or added to above policy(s) **(EOB attached or contact info)**
- 2. _____ Consumer's insurance coverage terminated/Date coverage termed _____. **(EOB attached or contact info)**
- 3. _____ New policy not indicated on Medicaid ID card **(EOB or copy of insurance card attached)** Indicate type coverage:

_____ Major Medical	_____ Hospital/Surgical	_____ Basic Hospital
_____ Dental Only	_____ Accident/Indemnity	_____ Nursing Home
_____ Vision Only	_____ Prescriptions Only	_____ Medicare Supplement

Contact Information

Insurance Carrier: _____
 Contact Person: _____
 Telephone Number: _____

Attach original claim, a copy of the EOB or a copy of insurance card and submit to: PBH/Reimbursement, 245 LePhillip Court, Concord, NC 28025. If you have any questions please contact your customer service representative for assistance.

Provider Name: _____ **Provider Number:** _____
Submitted By: _____ **Date Submitted:** _____
Telephone Number: _____