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: ____________________

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