

## **HEALTH INSURANCE CLAIM FORM**

Mail to: EBMC 4789 Rings Road Dublin, OH 43017

STATE   STAT	STATE   STAT	ATIENT'S NAME (Last Name, First Name, Middle Initia	3. PATIENT'S BIRTH	DATE SEX	4. INSURED'S NAME (Last Nar	ne, First Name, Middle Initial)		
STATE   STAT	STATE   0PATIENT STATUS   100	'ATIENT'S ADDRESS (No., Street)			7. INSURED'S ADDRESS (No.,	Street)		
THE PROVE (Notice Area Code)	THER INSUREDS NAME CALE PROPERLY   SELECTION   Company of the property   Company of the proper	Υ	STATE 8. PATIENT STATUS		CITY		STATE	
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VES NO   NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)   22 MEDICALD RESUBMISSION ORIGINAL REF. NO.   23 PRIOR AUTHORIZATION NUMBER   24 PRIOR AUTHORIZATION NUMBER   25 PRIOR AUTHORIZATION NUMBER   26 PRIOR DIVINE   27 ACCEPT ASSIGNMENT?   28 TOTAL CHARGE   29 AMOUNT PAID   30 BALANCE DUE   30 BA	INPI  LOCATION NUMBER  SIND  S	AME OF REFERRING PROVIDER OR OTHER SOU			MM DD YY MM DD YY			
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