

Supporting Documentation – Standard Cover Sheet

Health Plan: _____ Product: _____

Attention: _____

Date Cover Sheet Prepared: _____

◆ Use ONE cover sheet per submitted claim & **DO NOT** attach a copy of the claim. ◆
DO NOT use for a corrected claim OR request for review.

Original Claim

Number (from voucher): _____



Check here if claim was submitted electronically

Claim Identification Information:

Patient First Name: _____ MI: _____ Last: _____

Patient Date of Birth: - - Date(s) of Service: _____

Provider of Service: _____ Tax ID#: _____

Subscriber/Member ID# with prefix (when appropriate): _____

Subscriber's First Name: _____ MI: _____ Last: _____

Provider Office Contact Person:

Name: _____ Phone Number: _____

Other information: _____

Comments (Optional):

List of the documentation you attached:

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