Claim Referral

Provider Details

Company: ____ Tax ID: ______________________

Address: ____

Your Name: ___________________________________ Title: ___________________________

Phone#: (_____) ______________________ E-Mail: ____________________________________

Referral Details *(if multiple, attach list)*

Patient Name: ___________________ DOB: ________ Insured Name: ____________________

Insurance: _______________________ ID#: ________________ Group#: _________________

Claim(s) From: ____________________ Thru: ______________________

Amount of claim or total of claims: $______________ Denial Date: ________________

Please provide copy of insurance card, authorization, claim, explanation of benefits and any other correspondence available regarding this claim.

Submit referral form and documents via Submit Details on hbpconsult.com or fax to 954.564.3500.

Questions? Call us at 917.548.3473 or by e-mail at frank@hbpconsult.com

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