CLAIMS RECOVERY

Patient Name:	Patient Date of Birth:
Subscriber Name:	Subscriber Date of Birth:
Insurance Company:	Insurance Phone Number:
Insurance Representative Name:	Call Reference #:
Date of Service:	Treatment and Amount Submitted:
Has insurance company received claim? YES If yes, who was paid? Subscriber or provider? Has check been cashed?: Date and check number: If insurance company has received claim, but has not yet paid, why not? What do we need to do to get claim processed and paid? Additional information needed? X-ray films? Perio Charting? Narrative? Who is sending this info and when?	Has Insurance Company Received Claim? NO If no, does claim need to be resubmitted? Fax (verify number) Paper (verify mailing address) Electronically (verify payer ID) Who will resubmit claim and when?
Additional Notes:	Additional Notes:

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