Denied Information Received ☐
Missed Releases ☐
First time Reveiving Information ☐

Employee: ________
Insured's SS#: ________
Patient: ________
Claim # :
Can be any pended/denied claim number for the patient
Group #: ________

Date: ________

CSR: ________

Group Name: ________ **Adjusters initials:** ________

Caller: ________

Is your Spouse Employed? Yes ☐ No ☐ **Caller's #:** ________

If Yes, Spouses Employers Name: ________

Spouses Employers address: N/A ________

Does your spouse have Medical/Dental coverage with this employer? Yes ☐ No ☐

Is your spouse eligible to have Medical/Dental coverage with this employer? Yes ☐ No ☐

Is you spouses coverage single or family coverage? ________

If yes to family coverage - what is the spouses birthdate? ________

If yes: Name , Address and telephone number of insurance.

____

Spouses Insurance Effective date:

***Did your spouse have Medical/Dental coverage with this employer?** Yes ☐ No ☐

Spouses Insurance termination date: ________

	Mother	Father
****Which natural parent has court appointed Financial responsibility for children?**	☐	☐
****Which natural parent has the court appointed custody of children?**	☐	☐

***A letter of credible coverage must be submitted from the previous carrier showing the termination date.**
**** No divorce decree is required**

Note to examiner:

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