COB for Out-of-Network Services Claim

Patient Information

Patient Name Date of Birth Member ID

Address

Primary Insurance Details

Insurance Company Policy Number Group Number

Policyholder Name Relationship to Patient

Secondary Insurance Details

Insurance Company Policy Number Group Number

Policyholder Name Relationship to Patient

Service Information

Date(s) of Service Provider Name Provider NPI/ID

Out-of-Network Reason

Claim Details

Total Billed Amount Amount Paid by Primary

Amount Paid by Patient

Attach Explanation of Benefits (EOB) Choose File No file selected

Signature

Name Date