

Skilled Nursing Facility Care Claim Form

Patient Name	<input type="text"/>
Date of Birth	<input type="text"/>
Patient ID/Policy Number	<input type="text"/>
Facility Name	<input type="text"/>
Facility NPI Number	<input type="text"/>
Admission Date	<input type="text"/>
Discharge Date	<input type="text"/>

Diagnosis Code(s)	<input type="text"/>
Type of Care	<input type="text"/>
Services Provided	<input type="text"/>

Attending Physician Name	<input type="text"/>
Physician NPI Number	<input type="text"/>
Total Charges	<input type="text"/>
Claimant Name	<input type="text"/>
Date	<input type="text"/>
Additional Comments / Notes	<input type="text"/>