Out-of-Network Health Claim Form

Patient Information					
Full Name					
Date of Birth					
Member ID					
Phone Number					
Address					
Provider Information					
Provider Name					
Provider Address					
Provider Phone					
Claim Details					
Date of Service					
Diagnosis/Reason for Visit					
Procedures/Treatments					
Total Charges					
Amount Paid					
Additional Information					
Notes					
Attachments					
Receipts/Supporting Documents Choose File No file selected					