INSURANCE BILLING AND CONTROL LOG

Check one:

☐ Worker's Comp ☐ Private Pay ☐ Group Ins. ☐ Medicare ☐ Other _____

PATIENT INSURANCE INFORMATION

Date _____ Account/Control No. _____

Patient's name _____ Date of birth _____ Soc. Sec. No. _____

Patient's address _____

Date of first office visit _____ Home phone _____ Work phone _____

Owner of vehicle _____ Relation to patient _____

Insurance carrier _____ Whose Ins.? _____

Claims office address _____ Out of State ☐ Yes ☐ No

Policy No. _____ Expiration date _____ Limit $_____ PPO _____

Type of insurance ☐ Auto/Med pay ☐ Health ☐ Workers' Compensation ☐ Other _____

AUTO INFORMATION (Check one) ☐ Passenger ☐ Driver ☐ Pedestrian

Date of injury _____ Doctor's release date _____

Attorney _____ Comments _____

Address _____ Phone No. _____

Lien forms (Date sent to Attorney) _____ Date Returned _____

Insurance Company _____

Billing Address _____ Phone No. _____

Assignment form (Date sent to Insurance Company) _____

Insurance verified by who _____ How _____

Date verified _____ Verification check list on file ☐ Yes ☐ No

AUTO INSURANCE (Medical Payment)

a. **PRIMARY INSURANCE CARRIER** (Car patient was in) _____

Insured's name (car owner) _____ Phone No. _____

Billing address _____

Policy No. _____ Claim No. _____ Contact _____

Insured's date of birth _____ Soc. Sec. No. _____

b. **SECONDARY INSURANCE CARRIER** (Patient's car or one owned by relative or household member)

_____ Relation to patient _____

Insured's name _____ Phone No. _____

Billing address _____

Policy No. _____ Claim No. _____ Contact _____

Insured's date of birth _____ Soc. Sec. No. _____

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c. **UNINSURED MOTORIST APPLICATION** (Applies if other car is responsible for accident and other car is either a "hit and run" or is uninsured).

☐ Hit and Run ☐ Adverse care uninsured

Available insurance (Patient's car or insurance from relative or household member)

Insured's name _____ Date of birth _____

Phone No. _____ Relation to patient _____

Insurance Company _____ Phone No. _____

Address _____

Policy No. _____ Claim No. _____ Contact _____

HEALTH INSURANCE INFORMATION

Patient's Name _____ Date of birth _____

Insurance Carrier _____

☐ Individual (Policy No.) _____ ☐ Group. No. _____ Group name _____

Billing address _____ Phone _____

Deductible (if applies to accident injury) $_____

Policy coverage $_____ X-rays $_____ Office visits $_____

Orthopedic devices $_____ Supports and braces $_____

Exemptions _____ Other limitations _____

ANY OTHER INSURANCE CARRIERS WHICH MAY BE AFFECTED BY THIS CLAIM? _____

_____

_____

_____

Did this accident occur during work hours? (Workers' Compensation)

☐ Yes ☐ No Was employer notified? ☐ Yes ☐ No Date & time notified _____

Patient Signature _____ Date _____

MEDICARE INSURANCE INFORMATION

Name of insured (as shown on I.D. Card) _____

Address _____ City _____ State _____ Zip _____

Photo copy of I.D. Card on file ☐ Yes ☐ No

Disclosure letter signed by patient and on file ☐ Yes ☐ No Date _____

Office policy signed and on file ☐ Yes ☐ No

CASE TYPE APPROVED ☐ PI ☐ WC ☐ PP ☐ MC ☐ Other _____

DATE APPROVED _____ Approved by _____
(OFFICE PERSONNEL)

COMMENTS:

ATTACHED: Photocopy of insurance I.D. Card ☐ Yes ☐ No

HCFA #1500 Claim form signed ☐ Yes ☐ No

DATE BILLED	AMOUNT BILLED	TREATMENT DATES FROM/TO	CLAIM NO.	TO WHOM BILLED CARRIER/OTHER	DATE TRACER SENT	DATE PAYMENT RECEIVED	AMOUNT RECEIVED	BALANCE DUE	POSTED BY WHOM	ACTION PENDING	
										YES	NO

TELEPHONE AND COMMUNICATION LOG

DATE OF CALL	TIME OF CALL	PERSON CALLING	NAME OF PERSON SPOKEN TO	CONVERSATION	ACTION PENDING YES	NO

INCOMING CORRESPONDENCE LOG

DATE LETTER	LETTER FROM	PERSON SIGNED LETTER	DATE RECEIVED	CLAIM NO.	COMMENTS	ACTION PENDING YES	NO