SANTÉ COMMUNITY
PHYSICIANS

Supporting Documentation – Standard Cover Sheet

Health Plan: **Date Cover Sheet Prepared**: _____

Attention: Cost Containment

Use ONE cover sheet per submitted claim & <u>DO NOT</u> attach a copy of the claim. <u>DO NOT</u> use a corrected claim OR request for a review.

Original Claim Number (from EOB): _____

Date of Service:_____

Patient First Name:_____ MI:_____ Last Name:_____

Patient DOB:

Provider of Service:_____

NPI:_____ Tax ID:_____

Subscriber/Member ID: _____

Subscriber First Name:_____ MI:_____ Last Name:_____

Provider Office Contact Person:

Name:_____ Phone Number:_____

Comments:

_____
_____
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_____
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