The Heart Attack & Stroke **Prevention Center**
Breaking ground with the Bale/Doneen Method

Bale Doneen METHOD

Universal Insurance Claim Form

Please send reimbursement to the patient listed below.
This form replaces HCFA. The patient has paid provider for services.

Patient instruction: *Submit a copy of your insurance card and a copy of your bill slip along with this universal insurance form to your insurance company.*

Primary insurance company _____

Primary insurance company's address

Street _____ City _____ State _____ Zip Code _____

Policy holder's last name _____ First name _____ Middle initial _____

Policy holder's birthday (month/day/year) _____

Policy holder's employer _____

Date of service _____ ID number _____ Group number _____

Patient's last name _____ First name _____ Middle initial _____

Patient's address

Street _____ City _____ State _____ Zip Code _____

Patient's home phone _____ Patient's date of birth _____

Referring physician _____ Federal Tax ID#: 20-5689694

Total fees paid out of pocket $ _____ Cash ☐ Check ☐ _____ *(Include check number)* Credit card ☐

Patient (or guardian's) Signature _____

Insurance company Please see attached encounter form for diagnosis, ICD-9 codes, and procedure codes.

Secondary insurance company _____

Secondary insurance company's address

Street _____ City _____ State _____ Zip Code _____

Secondary insurance policy holder's last name _____ First name _____ Middle initial ___

Secondary insurance policy holder's address (if different from above)

Street _____ City _____ State _____ Zip Code _____

Secondary policy holder's birthday (month/day/year) _____

ID number _____ Group number _____

Provider signature is provided on the bill slip attached to the universal claim form.

507 S. Washington Suite #170 | Spokane, WA 99204 | Phone: (509) 747-8000 | Fax: (509) 747-8051 | www.thehaspc.com