**CLAIM INFORMATION REQUEST**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hello-

The above-named patient was seen in our office on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attempted to call you for this information on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide requested information via FAX to: 203-637-5408. Please contact Karyna with any questions.

**I authorize and request you to release records to:** Old Greenwich Medical Group, Billing Department

Please provide the following information for billing purposes:

1. Claim Number
2. Company name and claims billing address
3. Date of loss
4. State of incident
5. Injured body part
6. Adjuster’s Name – Telephone number – Fax number
7. Is patient’s condition related to employment?

ATTN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_