Coastal Bend Blood Center

Giving so that others may live

GROUP AND COMMUNITY BENEFITS PROGRAM CLAIM FORM

CONTACT INFORMATION *(Please Print)*

Patient Name: ______

Date of Birth: ______

Mailing Address: ______

City, State, Zip ______

Telephone: ______

Contact Name (if not patient): ______

Relationship to Patient: ______

Telephone: ______

BENEFIT PROGRAM INFORMATION *(Please Print)*

Please select from the following program options:

☐ **GROUP BENEFIT PROGRAM**

Donor Group Affiliation: ______

Number of Group Credits to be Released: ______

Donor Group Number: ______

Donor Group Chairperson: ______

Chairperson Signature: ______

☐ **COMMUNITY BENEFIT PROGRAM**

	Donor Name:	Date of Birth:		Donor Name:	Date of Birth:
1.			3.		
2.			4.		

Attach supplementary pages as necessary for additional donors.

INSURANCE INFORMATION

Does patient have insurance? ☐ Yes ☐ No

If yes, what provider? ☐ Medicare ☐ Medicaid ☐ Other *(please specify)*: ______

Please provide a copy of the insurance company's Explanation of Benefits along with detailed hospital bill showing itemized blood fees and dates of service. Reimbursement cannot be issued without this documentation.

By signing below, I attest that the information provided above is true and accurate.

Authorized Signature: ______ Date: ______

Submit Claim to:

Coastal Bend Blood Center
Attn: Erin Survant
209 N. Padre Island Drive
Corpus Christi, TX 78406

Telephone: (361) 737-0419
(800) 299-4943
Fax: (361) 855-2641
E-mail: info@coastalbendbloodcenter.org

FOR BLOOD CENTER USE ONLY

Verified By	Date Verified	Posted By	Date Posted	# Credits Requested	# Credits Available	# Credits Released	Amount	GL#	Approved By	Date Paid