Healthcare Consulting & Billing Solutions, Inc.

Provider details

Your information

Company/Tax ID: _____

Address: _____

Your name/title: _____ / _____

Your phone/email: (____) _____ / _____

Patient and claim details

Referral information

Patient name & DOB: _____ /_____

Insurance and ID #: _____ / _____

Claim from: _____ thru: _____

Amount of claim: $_____ Denial date: _____

Additional details

Denial information

Reason for denial/actions already taken: _____

_____

_____

_____

Please provide copy of insurance card, authorization, claim, explanation of benefits and any other correspondence available regarding this claim.

Submit referral form and documents via Contact Us at hcbsinc.com or fax to 954.564.3500. Questions? Call 917.548.3473 or email frank@hcbsinc.com.