

FOR PROVIDER USE ONLY

Account Number _____

Date of Service _____

Effective Date _____

Expiration Date _____

Patient is eligible for:	Patient Responsibility
Plan 1	\$10
Plan 2	20%
Plan 3	40%
Plan 4	60%
Plan 5	80%

Date Received _____ Received by _____

Date Processed _____ Processed by _____