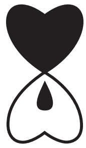

BLOOD ASSURANCE CLAIM FORM

PATIENT INFORMATION

Name: ____________________

Date of Birth: ____________________

Address: ____________________

City, State, Zip: ____________________

Telephone: ____________________

DONOR INFORMATION (If different from patient)

Name: ____________________ Date of Birth: ____________________

Donor Group Affiliation (if any): ____________________

CONTACT PERSON (If not patient)

Name: ____________________ Telephone: ____________________

Relationship to Patient: ____________________

INSURANCE INFORMATION

Does patient have insurance? ☐ Yes ☐ No

If yes, what provider? ☐ Medicare ☐ Medicaid

☐ Other (please specify): ____________________

If insurance is not Medicare or Medicaid, please provide a copy of the insurance company's Explanation of Benefits

HOSPITAL INFORMATION

Hospital where services provided: ____________________

Location: ____________________ Patient's Hospital ID# (or SSN): ____________________

Dates of Service: ____________________

Please read and sign the release below:

I hereby authorize the above-named hospital to release information regarding my blood product usage to The Blood Center.

Patient Signature: ____________________ Date: ____________________

Submit Claim to:

The Blood Center
Attn: Patient Claims
2609 Canal St.
New Orleans, LA 70119

Telephone: *(504) 524-1322*
(800) 86-BLOOD (Ext. 1561)
Fax: *(504) 592-1578*
Email: *PatientClaims@TheBloodCenter.org*

REQUEST FOR PATIENT USAGE INFORMATION- FOR HOSPITAL USE ONLY

Hospital Representative:
Please complete the usage information for the above-refrenced patient and return to The Blood Center

Date	Product Type	# Units Transfused
	Whole Blood	
	Red Blood Cells	
	Platelets	
	Fresh Frozen Plasma	
	Other:	

Hospital Representative Signature: ____________________ Date: ____________________

FOR BLOOD CENTER USE ONLY

Date Received	Confirm	Date to A/P	Amount		Verified	Date Paid
				5510-03		