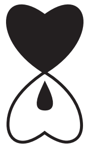

BLOOD REPLACEMENT CLAIM FORM

PATIENT INFORMATION

Name:____

Date of Birth:____

Address: ____

City, State, Zip: ______________________________________

Telephone: ____

CONTACT PERSON (If not patient)

Name:____ Telephone:______________________

Relationship to Patient: ____

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 Accounting
2609 Canal St.
New Orleans, LA 70119

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

FOR BLOOD CENTER USE ONLY

Date Claim Received:

____

Claim #: ______________

Donations	Yes/No	Date
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		