



# THE BLOOD CENTER

*Serving you for life!*

# 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* Telephone: *(504) 592-1534*  
*Attn: Patient Claims Accounting* *(800) 86-BLOOD (ask for extension 1534)*  
*315 S. Johnson St.*  
*New Orleans, LA 70112*

### REQUEST FOR PATIENT USAGE INFORMATION - FOR HOSPITAL USE ONLY

*Hospital Representative:*  
Please complete the usage information for the above-referenced 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		