



THE BLOOD CENTER BLOOD REPLACEMENT CLAIM FORM

Serving you for life!

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: _____

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

FOR BLOOD CENTER USE ONLY			
Date Claim Received: _____	Donations	Yes/No	Date
Claim #: _____	January		
	February		
	March		
	April		
	May		
	June		
	July		
	August		
	September		
	October		
	November		
	December		