



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)*
2609 Canal St. Fax: *(504) 592-1580*
New Orleans, LA 70119

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		