ADVANTAGE RADIOLOGY SERVICE

(844) 283-4163

CASH (no insurance)_____ MEDICARE ONLY _____ MEDICAID ONLY_____

STANDARD

NEED NON-PARTICIPATING PROVIDER INSURANCE NAME & BILLING ADDRESS
***PLEASE ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S).**

INSURANCE NAME & BILLING ADDRESS PRIMARY			INSURANCE NAME & BILLING ADDRESS SECONDARY		
CARRIER	TELEPHONE		CARRIER	TELEPHONE	
ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER_____			RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER_____		
INSURED NAME	INSURED DATE OF BIRTH		INSURED NAME	INSURED DATE OF BIRTH	
INSURED SOCIAL SECURITY #	INSURED ID #		INSURED SOCIAL SECURITY #	INSURED ID #	
INSURED GROUP #	BCBS 3 LTR PREFIX		INSURED GROUP #	BCBS 3 LTR PREFIX	
INSURED EMPLOYER	TELEPHONE		INSURED EMPLOYER	TELEPHONE	

AUTO ACCIDENT/PI/WORKERS' COMPENSATION

RELATED TO EMPLOYMENT? YES NO
AUTO ACCIDENT? YES NO
OTHER? YES NO

DATE OF INJURY_____

W/C CARRIER OR AUTO CARRIERS			ATTORNEY NAME & BILLING ADDRESS		
CARRIER	TELEPHONE		ATTORNEY NAME	TELEPHONE	
INSURANCE ADDRESS			ATTORNEY ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER_____			*PLEASE LIST BOTH LIABILITY AND MED PAY CARRIERS USE ADDITIONAL PAPER IF NECESSARY		
CLAIM NUMBER	INSURED NAME		IF W/C: EMPLOYER ADDRESS	CITY / ST	ZIP
IF PI: ADJUSTERS NAME	ADJ: TELEPHONE		IF W/C: ALLOWED DIAGNOSIS ICD-9 CODES		

PLEASE COMPLETE PATIENT HISTORY ON REVERSE SIDE