ALLEGRO MEDICAL BILLING

PATIENT DATA INPUT FORM

TEAM:____ CO#:____ PROVIDER:_____

PATIENT :_____ SSN# _____

PATIENT ADDRESS:_____

CITY/STATE/ZIP:_____

PATIENT PHONE#:_____

D.O.B. _____ SEX: M _____ F_____ HEIGHT_____ WEIGHT_____

ICD-9 (Diagnosis) CODE (s) _____ _____ _____ _____

PRIMARY INSURANCE: (Circle one) MEDICARE MEDICAID OTHER

(Address Required)

Medicare / Patient Identification Number _____ Group_____

Name of OTHER Insurance _____

ADDRESS _____

Street City State Zip

SECONDARY INSURANCE : _____

Address:_____

PHONE _____CITY/STATE/ZIP_____

POLICY ID #_____GROUP#_____

Do you wish to: ACCEPT ASSIGNMENT - Y / N Amount Patient Paid - $_____

DATE OF SERVICE : _____ (Coding Hotline Ph 877-735-1326)

ITEM CODE (and description) _____ Quantity _____ Unit Price _____

ITEM CODE (and description) _____ Quantity _____ Unit Price _____

ITEM CODE (and description) _____ Quantity _____ Unit Price _____

ITEM CODE (and description) _____ Quantity _____ Unit Price _____

ITEM CODE (and description) _____ Quantity _____ Unit Price _____

PHYSICIAN NAME : _____

PHYSICIAN NPI#: _____

ADDRESS : _____

Phone: _____ City/State Zip: _____