ASR LIEN RESOLUTION PROGRAM

PROVIDER DATA FORM

Claimant Name (Last, First, Middle)	
Claimant DOB (mm/dd/yyyy)	
Claimant SSN (xxx-xx-xxxx)	
Provider Tax ID Number	
Place of Service (POS) Code, 1-81	
Provider Name / Location (for example: Memorial Hospital, Kentucky)	
Diagnosis related group (DRG) Assignment	

☐ Hospital
- ☐ General Acute
- ☐ Rehabilitation
- ☐ Long term acute care (LTAC)
- ☐ Other________________________

☐ Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS)
☐ Skilled Nursing Facility (SNF)
☐ Home health agency (HHA)
☐ Hospice
☐ Outpatient physical therapy
☐ Ambulatory Surgery Center
☐ Independent Diagnostic Testing Facility
☐ Physician
☐ Clinical lab
☐ Other ____________________________________

DESCRIPTION OF OUTSTANDING BILL

(must be completed in order to review claim)

Check all boxes that apply

☐ Patient was uninsured
☐ Patient was insured but outstanding amount represents an out of pocket expense (Co-pay / deductible)
☐ Patient was insured but service / treatment not covered by insurance
☐ Patient was insured but insurance was not billed
☐ Other (please explain)____

Dates of Service DOS mm/dd/yyyy	ICD-9 CM code(s)	Description of Service	Procedure services /supplies (codes)	Amount billed	Amount paid (if applicable)	Insurance payments (Y/N)	Payer name	Amount paid by payer	Insurance Contractual Adjustment Amount	Remaining Balance