

INDIVIDUAL BILLING CONTRACT

Date ____/____/____

Client Name (s) _____ DOB ____/____/____
_____ DOB ____/____/____

Marital Status S M D W (circle one)

If Trust or Estate,
Trustee or Agent Name _____

_____ Telephone # () _____

Special Instructions _____

Service: National Billing Associates, LLC, or NBA, will provide insurance claim filing for the above named client(s). Reimbursement for eligible medical service will be claimed from the insurance carriers listed below. Please complete as accurately as possible.

Medicare ID# ____ - ____ - ____ SS# ____ - ____ - ____
Effective Date ____/____/____

Other Insurance

#1. Insurance Company Name _____
Address _____
_____ Telephone# () _____
Policy ID# _____ Group# _____
Notes: _____

#2. Insurance Company Name _____
Address _____
_____ Telephone# () _____
Policy ID# _____ Group# _____
Notes: _____

____ Additional insurance carries on reverse side.

NOTE: I authorize NBA to file health insurance claims on my behalf to the carriers listed above. I agree to provide NBA with all medical receipts and/or bills, with all explanation of (Medicare) benefits forms; which I receive so that claim filing can be completed.

SIGNATURE: _____

Rate: Annual Fee \$ _____ Hourly Fee \$ _____

*If an Estate account, please attach a copy of Death Certificate and letters of Administration (documents identifying personal representative).