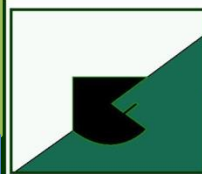


# E.O.B. Verification Form



**F E B C O**

**Benefits Consultants**

Form: EOBVERIFICATION08062013

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Email Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birthday: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Fill Out form completely and attach a copy of your E.O.B.'s Once completed, fax this form and your supporting E.O.B.'s to Febco.

## EOB #1

Patient's Name: \_\_\_\_\_

Amount of Charge: \$ \_\_\_\_\_ \*Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Merchant/Doctors Name: \_\_\_\_\_ \*Deduct from Previous Plan Year:

Description of Service: \_\_\_\_\_

## EOB #2

Patient's Name: \_\_\_\_\_

Amount of Charge: \$ \_\_\_\_\_ \*Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Merchant/Doctors Name: \_\_\_\_\_ \*Deduct from Previous Plan Year:

Description of Service: \_\_\_\_\_

## EOB #3

Patient's Name: \_\_\_\_\_

Amount of Charge: \$ \_\_\_\_\_ \*Dates of Service: \_\_\_\_\_ to \_\_\_\_\_

Merchant/Doctors Name: \_\_\_\_\_ \*Deduct from Previous Plan Year:

Description of Service: \_\_\_\_\_

**\*\*\*This is not a claim form\*\*\***

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax this form to: 502-695-9692  
[www.febco.com](http://www.febco.com)

**Febco Inc.**  
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