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

Febco Inc.
PO Box 5010
Frankfort KY 40602
1-800-489-1539