The AirwayCompany

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Dear Patient: Thank you for choosing The Airway Company. For reimbursement from your insurance, please submit this form to your insurance's billing address with a copy of your payment for our services. For information on your insurance's billing address, please contact the number for customer service on the back of your insurance card and ask the representative where you can mail in your claims.

Please note: submission of this form does not guarantee reimbursement from your insurance. Reimbursement is based on your individual plan benefits and coverage by your insurance carrier.

ATTN: TO CLAIMS PROCESSING
Attached is the billing information related to services or devices rendered by The Airway Company. I have paid for these services or devices and am requesting reimbursement from my medical insurance company. Please see the attached billing information and a copy of my receipt for services or devices rendered. Please make check payable to the address I have specified below and call me at the phone number provided. Thank you, *Patient/Guardian Signature* _____ *Date* _____

ORDER DATE: / /			TODAY'S DATE: / /
PATIENT INFORMATION			
Patient's Last Name:			Patient's First Name:
Social Security Number:	Birth Date: / /	Sex: ❑ M ❑ F	Patient's Phone Number:
Patient's Street Address:			
P.O. Box:	City:	State:	ZIP Code:
Medical Insurance Name:	Subscriber ID:		Subscriber Group:

ORDER INFORMATION			
CPT Code	Date of Order	Description	Billed Amount
TOTAL PAYMENT:			