



REQUEST FOR INFORMATION

Date: _____

Dear AmeriCorps Member:

Please give this form to your healthcare provider with your identification card.

Provider Name: _____ Patient Name: _____

Provider Address: _____ Certificate #: _____

City: _____ State: _____ Zip: _____

Dear Healthcare Provider:

Please provide the following medical information and staple this form to the claim prior to submission for reimbursement. Receiving this information with the claim will expedite claim processing and payment. Thank you.

1. On what date did the patient first consult you with symptoms related to this condition? _____

2. On what date was this condition originally diagnosed?

Date: _____ Diagnosis Code: _____ Date: _____ Diagnosis Code: _____

3. If the patient consulted another physician(s) prior to consulting you, please indicate the name and address of the physician(s):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

4. Was the patient taking prescription drugs on a daily, weekly or monthly basis before consulting you for treatment?

Yes ___ No ___

If yes, please specify medication: _____

I certify the above information is true to the best of my knowledge.

Signature: _____ Date: _____ Tax ID#: _____

Please mail to:

AmeriCorps
Attn: Claims
P.O. Box 3430
Carmel, IN 46082-0340

Customer Service
AmeriCorps Programs

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