

**Add Insurance Form**  
(Formerly County/Misc. Code Form)

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Use this form to have payer information added to the Community Practice Services database

**Please fax Completed report to: 513-636-0504**

<b>Requested by:</b>	<b>Practice Name:</b>
<b>Date:</b>	<b>Practice Fax #:</b>
<b>Pages including cover page:</b>	
<b>Insurance Name:</b>	

<b>Address 1:</b>
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<b>Address 2:</b>
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<b>City, State, Zip:</b>
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<b>Phone with area code: (      )</b>
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<b>Patient Account / Encounter #</b>	<b>D.O.S.</b>
<b>Managed Care Contract:</b>	
<b>Notes:</b>	

Received Date: \_\_\_\_\_ Received By: \_\_\_\_\_ Added By: \_\_\_\_\_ Added Date: \_\_\_\_\_