



# INSNET

## Claim Referral Form

Please complete this form and fax or email it along with your provider statement

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*Contact Person*

\_\_\_\_\_

*Patient First Name*

*Patient Last Name*

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\_\_\_\_\_

*Patient Date of Birth*

*Patient Social Security Number*

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\_\_\_\_\_

*Medical Provider Name*

*Telephone Number*

\_\_\_\_\_

\_\_\_\_\_

*Total Amount Billed*

*Amount Paid by Insurance*

\_\_\_\_\_

\_\_\_\_\_

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Fax to: 207-885-0188

Email to: [claims@myinsnet.com](mailto:claims@myinsnet.com)