

HML Bill Reconciliation Form

Fax to Adura L. at HML Billing Office at 651-232-1328 or email alansiquot@healtheast.org

Customer Name: _____ Account #: _____ Statement Date: _____

		Patient Information:			Insurance Information:			
Transaction Date	Request No.	Name	DOB	Address & Phone	Company Name	Policy #	Group #	Diagnosis Code

Completed by: _____ Phone #: _____ Date: _____

Please remit within 30 days of receipt of your billing statement.