THE BLOOD CENTER BLOOD REPLACEMENT CLAIM FORM

Serving you for life!

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Telephone: _____

CONTACT PERSON (If not patient)

Name: _____ Telephone: _____

Relationship to Patient: _____

HOSPITAL INFORMATION

Hospital where services provided: _____ Location: _____

Please read and sign the release below:

I hereby authorize the above-named hospital to release information regarding my blood product usage to The Blood Center.

Patient Signature: _____ Date: _____

Submit Claim to: *The Blood Center*
Attn: Patient Claims Accounting
2609 Canal St.
New Orleans, LA 70119

Telephone: *(504) 592-1534*
(800) 86-BLOOD (ask for extension 1534)

Fax: *(504) 592-1578*

FOR BLOOD CENTER USE ONLY

Date Claim Received: _____

Claim #: _____

Donations	Yes/No	Date
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

Rev. 10/2013