AmeriCorps*VISTA
AmeriCorps*NCCC

Dear AmeriCorps Member:

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

Date:

Provider Name:_________________________________ Patient Name: _______________________

Provider Address:______________________________ SSN:______________________________

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. What was the date of onset of this condition?

   Date:_________ Diagnosis Code:_________ Date:_________ Diagnosis Code:_________

3. If the patient was referred to you, please indicate the name and address of the referring physician:

   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 staple this form to your medical claim and mail to:

ForMost, Inc.
P.O. Box1659
Portland, OR 97207-1659
Customer Service
AmeriCorps Programs

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