



Claim Referral Form

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

Name of Patient

*Contact Person – if
different than patient*

Patient Date of Birth

*Last 4 digits of Social Security number
– for identification purposes*

Name of medical provider

Medical Provider phone #

Total amount of bill

Amount paid by insurance

Patient Balance

**Upon receipt of this form, an INSNET representative will contact you
to collect your credit/debit card information for pre-authorization**

Fax to: 877-641-9923

Email to: claims@myinsnet.com