



RIGBY
GROUP BENEFITS

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Claim Resolution Form

Employer: _____

Email Address: _____ Insurance Co: _____

Employee's Name: _____ SS #: _____

Patient's Name: _____ Date(s) of Service: _____

Billing Provider: _____ Amount: _____

Summary of Problem (Please include copies of the explanation of benefits, bills and any other paper-work to help resolve this problem.): _____

For Office Use Only:

Date	Action Taken

Initials: _____

Entered: _____

Comp Date: _____

Resolution: _____
