NECA Insurance Questionnaire

Participant Name: _____

ID Number: _____

Address: _____

_____

Phone Number: _____

Person Claim is on: _____

Date of Service: _____

Doctor/Facility: _____

Issue and/or Denial: _____

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Please complete the attached Customer Service Consent Form and return to this office along with the completed questionnaire and copies of any EOBs concerning this matter.
Fax to: 256-383-0907 or Email to: pbyrd@ibew558.org or kwilliams@ibew558.org