



BILL REVIEW/BILL NEGOTIATION REFERRAL

Fill out form and attach with bill(s) - UB-94/UB-92; CMS-1500 and supporting medical report(s) and email to: billreview@lienonmeinc.com

Claimant Name: _____

Client: _____

Claim #: _____

DOI: _____

Provider(s): _____

Comments/Special Instructions:

Phone Number

Email Address

Date

Client Signature

Client Name

LIEN ON ME, INC. OFFICE USE ONLY

UB-04/UB-92; CMS-1500

Medical Reports

DME Invoices (RC278)

Date Received

Received By

