Date: ______________________

Fax#: ______________________

Provider Name: ________________

Date: ______________________
700 Children's
Columbus, OH 43205
Phone: (614)355-9860
Fax: **(614)355-3185**

ATTN: Provider Relations Coordinator

Please complete this form and return to PFK with either a **copy of the HCFA or EOB claim form** to **(614) 355-3185**.

Proof forms must be received by PFK within 60 days of payment for the quarter in question.

* Indicates REQUIRED field

Patient Name (printed) as listed on Insurance card*: ____

Patient DOB*: ____________________

Managed Care Plan name*: ____

Managed Care Member ID*: ____

Please provide the date(s) of service is the appropriate table(s) below:

Well Child Checks	Dates of Service					
Age 15 Months (6)	/ /	/ /	/ /	/ /	/ /	/ /
Age 3-6 Years (1)	/ /					
Adolescent (1)	/ /					

Appropriate Usage of Antibiotics for Upper Respiratory Infection

Date of service: / /

☐ Additional documented diagnosis not coded, records attached.

______________ Additional Diagnosis Code

Office use only:

Appropriate Asthma Management RX filled date ____________________

Physician Signature (required) ____

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