

**VBH-PA
CLAIMS BATCH HEADER**

Provider Name: _____

Provider Number: _____

Date Batch Sent: _____

Provider Unique Batch ID # _____
(optional*)

Number of Claims Contained in Batch: _____

Billing Address:

Provider Billing/Claims Contact Person: _____

Phone Number (with area code): _____

Fax Number (with area code): _____

Number of claims counted by VBH-PA claims department: _____

Name of individual counting batch: _____

Date claims received and counted: _____

*This unique number is assigned by the provider to identify the batch. It is not the number of claims in the batch.

Batched claims will be counted upon arrival in the VBH-PA claims mailroom. If there is a discrepancy between the number of claims the provider indicates is in the batch and the number counted by the VBH-PA claims department, a copy of the Claims Batch Form will be returned to the provider indicating the count difference.