



## PROVIDER E.O.B. REQUEST FORM

### Provider Information (please print all information)

Provider Name: \_\_\_\_\_  
*Last* *First* *M.I.*

TIN: \_\_\_\_\_

NPI: \_\_\_\_\_

Claim # : \_\_\_\_\_

Date of Service: \_\_\_\_\_ Check Number: \_\_\_\_\_

Office Address: \_\_\_\_\_  
*(street)* *(city, state, zip)*

Office Phone:   ( )   Office Fax :   ( )  

Requested By \_\_\_\_\_

Title \_\_\_\_\_

Signature or Preparer \_\_\_\_\_

Contact Number \_\_\_\_\_

**NOTE:** An E.O.B. may **only** be requested by the provider or an office manager. Please allow two weeks to receive E.O.B. Please complete **entire** form – incomplete forms **will not** be accepted.

**Directions:** Please **fax** Provider E.O.B. Request Form to CeltiCare Member & Provider Services Department, Attn: Member Services, at **(617) 787-1497**, or **mail** it to:

**CeltiCare Member & Provider Services**  
**1380 Soldiers Field Road**  
**Suite 300**  
**Brighton MA, 02135**