AFFIDAVIT

Insurance Co. Name ______________________________
Claim #: ______________________________
Claimant ______________________________
SS# ______________________________
Date of Accident ______________________________

STATE OF ______________________

COUNTY OF ______________________

Provider Name: ____

Tax ID #: ______________________________

I certify that the bills for dates of service listed below have not previously been audited, reduced, or denied by the insurance company prior to receivership. I certify that payment has not been made either in full or in part for the dates of service listed.

(List each date of service below)

_________________	_________________	_________________	_________________
_________________	_________________	_________________	_________________
_________________	_________________	_________________	_________________
_________________	_________________	_________________	_________________
_________________	_________________	_________________	_________________
_________________	_________________	_________________	_________________
_________________	_________________	_________________	_________________
_________________	_________________	_________________	_________________
_________________	_________________	_________________	_________________
_________________	_________________	_________________	_________________

I have read the foregoing, it is true, and I sign this of my own free will and act.

Signed this _____ day of _________________________, 20___.
(Not Accepted Unless Notarized)

____

Subscribed and sworn to me, a Notary Public, in and for the County of ________________,
State of ____________________. This _____ day of ____________________, 20___.

____
Notary Public

**** Completion of this form in no way guarantees payment.**