PALMETTO GBA®
A CELERIAN GROUP COMPANY

COVID-19 Monoclonal Antibody Infusion Roster Form

Print Form

Palmetto GBA
PO Box 100190
Columbia, SC 29202

Providers should not bill for the product if they receive it FREE.
Providers must use separate forms for COVID-19 Vaccine and Monoclonal Antibody COVID-19 Infusions.

Provider Name: ____________________ Diagnosis Code ____________

NPI: ____________________ Antibody Infusion Product Code ____________

Date of Service: __________ (One date per roster) Administration Code ____________

Patient Information (Please PRINT or TYPE all elements clearly except patient/beneficiary's signature)

Medicare Number: __________ Date of Birth: __________ Sex: ☐ Male ☐ Female

Last Name: __________ First Name: __________ Middle Initial ____

Address: __________ City: __________ State: ____ Zip Code: ______

Patient's Signature: ______________________ ☐ Yes, if signature on file OR patient/beneficiary's signature

Medicare Number: __________ Date of Birth: __________ Sex: ☐ Male ☐ Female

Last Name: __________ First Name: __________ Middle Initial ____

Address: __________ City: __________ State: ____ Zip Code: ______

Patient's Signature: ______________________ ☐ Yes, if signature on file OR patient/beneficiary's signature

Medicare Number: __________ Date of Birth: __________ Sex: ☐ Male ☐ Female

Last Name: __________ First Name: __________ Middle Initial ____

Address: __________ City: __________ State: ____ Zip Code: ______

Patient's Signature: ______________________ ☐ Yes, if signature on file OR patient/beneficiary's signature

Medicare Number: __________ Date of Birth: __________ Sex: ☐ Male ☐ Female

Last Name: __________ First Name: __________ Middle Initial ____

Address: __________ City: __________ State: ____ Zip Code: ______

Patient's Signature: ______________________ ☐ Yes, if signature on file OR patient/beneficiary's signature

Medicare Number: __________ Date of Birth: __________ Sex: ☐ Male ☐ Female

Last Name: __________ First Name: __________ Middle Initial ____

Address: __________ City: __________ State: ____ Zip Code: ______

Patient's Signature: ______________________ ☐ Yes, if signature on file OR patient/beneficiary's signature

For Medicare Recipients: Signature on File indicates, "I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment."

December 2020