HealthySpace

CARES ACT

HRSA COVID-19 Uninsured Program

* Attach a copy of Driver License or Gov ID and Social Security Number

Date of Service: _____ Company name: _____

First Name: _____Middle Initial: _____Last Name:_____

Home Address: _____

State of Residence: _____ Driver License # : _____

Date of Birth: _____ Gender: _____

Social Security Number:_____ _____ _____

CMB attests that we attempted to capture the above information prior to submitting a claim.

I certified that the above patient has no Insurance, Federal, Private, nor

Medicare coverage. Patient status is uninsured.

Patient signature: _____