SDF-6
Explanation of Benefits

Claimant Name:
SDTF Claim No.:
Date of Accident:
Employer:
Provider I.D.:
Provider Name:
Provider Address:

Insurer Name:
Insurer Code No.:
Insurer FEIN:

Diagnosis: **1)** **3)**
2) **4)**

Service Dates: From	To	Procedure Codes	Description	Diag Code	Provider Charges	Recommended Reduction	Payment	EOB Code

Total Charged:
Reductions:
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Total Payable:
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Explanation of Benefits:

Form DFS-F1-SDF-6 (Rev. 1/31/2008)