# MEDICAL / DENTAL CLAIM FORM

P O Box 50190
Sparks, Nevada 89435-0190
(775) 352-7252

| PLEASE CHECK ONE | 1. COMPLETE THIS FORM |
|---|---|
| ☐ MEDICAL | 2. ATTACH ITEMIZED BILLS |
| ☐ DENTAL | 3. MAIL TO ➔ |
| ☐ VISION | |

## PLEASE FILL OUT THE FOLLOWING INFORMATION

| EMPLOYEE NAME | SOCIAL SECURITY # | EMPLOYEE BIRTHDATE | PHONE NO. |
|---|---|---|---|
| | | | |

| MAILING ADDRESS | CITY / STATE | ZIP |
|---|---|---|
| | | |

| PATIENT NAME (IF OTHER THAN EMPLOYEE) | MALE ☐ FEMALE ☐ | RELATIONSHIP TO EMPLOYEE | PATIENT BIRTHDATE | IS PATIENT MARRIED? YES ☐ NO ☐ |
|---|---|---|---|---|
| | | | | |

| IS PATIENT FULL TIME STUDENT? YES ☐ NO ☐ | NAME & ADDRESS OF SCHOOL | DATE ACCIDENT OR SICKNESS BEGAN |
|---|---|---|
| | | |

| IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN? | DID ACCIDENT HAPPEN AT WORK? YES ☐ NO ☐ | HAS CLAIM BEEN FILED WITH WORKERS' COMP? YES ☐ NO ☐ |
|---|---|---|
| | | |

| NATURE OF SICKNESS, INJURY OR DIAGNOSIS | PHYSICIAN'S NAME |
|---|---|
| | |

| NAME OF SPOUSE | BIRTHDATE | IS SPOUSE EMPLOYED? YES ☐ NO ☐ | NAME & ADDRESS OF SPOUSE'S EMPLOYER |
|---|---|---|---|
| | | | |

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP HEALTH PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR THE EXPENSES OF THIS CLAIM? YES ☐ NO ☐ IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF PLAN PROVIDING BENEFITS.

POLICYHOLDER: _____

NAME AND ADDRESS: _____

_____

SOCIAL SECURITY NO. _____

POLICY NO. _____

EFFECTIVE DATE: _____

## PATIENT OR PARENT MUST SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify this information provided is correct and true to the best of my knowledge.

X _____

Covered Person Date

## IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER(S):

I hereby authorize payment of benefits to any provider of service, otherwise payable to me for service, but not to exceed the reasonable and customary charges for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____

Covered Person Date