centrix BENEFIT ADMINISTRATORS

MEDICAL EXPENSES CLAIM FORM

EMPLOYEE INFORMATION

Employer's Name: | Occupation:

Employee's Name: | Social Security #:

Sex: | Marital Status: ◯ Single ◯ Married ◯ Head of Household | Date of Birth: | Date of Hire:

Employee's Home Address: (Street) (City) (State) (Zip)

COMPLETE IF YOU ARE MARRIED OR CLAIM IS FOR A DEPENDENT

Name of Your Spouse:

Is your spouse employed?
◯ No
◯ Yes - Name of Employer:_____

The expenses included in this claim were for medical services rendered solely to:

◯ Self

◯ Eligible Dependent - Name:_____

Relationship:_____

Social Security #:_____

Date of Birth:_____

Sex: ◯ Male ◯ Female

If the claimant is a dependent child:

Is the dependent employed? ◯ Yes ◯ No

Is the dependent claimed for tax purposes? ◯ Yes ◯ No

Is the dependent handicapped? ◯ Yes ◯ No

Is the dependent over age 18? ◯ Yes ◯ No

Is the dependent a full-time student? ◯ Yes ◯ No

School name/location:_____

COMPLETE IF CLAIM IS THE RESULT OF AN ACCIDENTAL BODILY INJURY

Where did the accident happen? | Date:

Describe the accident. Include how it happened.

OTHER INSURANCE

THIS PORTION MUST BE ANSWERED BEFORE THE CLAIM CAN BE PROCESSED.

Is the expense of this claim covered by any other group insurance, or any other arrangement of coverage for individuals in a group? ◯ Yes ◯ No

Name of Insurance Company:_____ Policy Number:_____

Address of Insurance Company:_____

Name of Insured:_____

EMPLOYEE'S STATEMENT

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer, having information available as to diagnosis, treatment and prognosis, with respect to any physical or mental condition and/or treatment of me, or my minor children, and any non-medical information of me, or my minor children, to give Centrix Benefit Administrators (CBA), the insurance company, or their legal representative any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by CBA to determine eligibility for benefits under an existing policy. Any information obtained will not be released by CBA to any person or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request that CBA send me a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be valid for one year from the date it is signed.

I AGREE to reimburse the Plan for any over-payment made to me in my behalf due to error.

_____ _____

SIGNATURE OF EMPLOYEE/CLAIMANT Date

(If this claim concerns a dependent age 18 or over, dependent should sign as the claimant.)
ATTACH ALL BILLS AND PRESCRIPTION RECEIPTS INCLUDING DRUG NAME.

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PATIENT INFORMATION

Patient's Name and Address:

Employer's Name:

AUTHORIZATION TO PAY BENEFITS: I authorize payment of benefits directly to the person or organization who provided care not to exceed the benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for charges not covered by the Plan (signed by employee or parent if patient is a minor):

PATIENT INFORMATION

Date of Illness (first symptom) or Injury (accident) or Pregnancy (LMP)

Has the patient ever had the same or similar problems?
- Yes
- No

- Hospitalized - From: Through:
- Partially Disabled - From: Through:
- Totally Disabled - From: Through:

Date patient is released to return to work:

Was laboratory work performed outside your office?
- Yes
- No

Name and address of facility where services rendered (if other than home or office):

Diagnosis or nature of illness or injury related diagnosis to procedure in column "D" by reference to numbers 1, 2, 3, etc. or Dx code:

1.

2.

3.

4.

A Date of Service	B Place of Service	C Procedure Code	C Procedure Description	D Diagnosis Code	E Billed Charges	F

Signature of physician or supplier:

Date:

Do you accept assignment? (Government claims only)
- Yes
- No

Your Social Security #:

Your Employer Tax I.D. #:

TOTAL CHARGE:	AMOUNT PAID:	BALANCE DUE:

Physician or supplier's name, address, zip code, and telephone #:

Place of Service Code:

1.	(H) - In-patient Hospital	5.	Psychiatric Day Care Facility	9.	Ambulance
2.	(OH) - Out-patient Hospital	6.	Psychiatric Night Care Facility	O	(OL) - Other Locations
3.	(O) - Doctor's Office	7.	(NH) - Nursing Home	A	(IL) - Independent Laboratory
4.	(HH) - Home Health	8.	(SNF) - Skilled Nursing Facility	B	Other Medical/Surgical Facility