INSTRUCTIONS FOR FILING A CLAIM

1. **This form can be used for all Benefis and Benefis physician claims.**

2. You must submit an itemized bill for your claim to be processed. Receipts, balance due statements and cancelled checks are not acceptable replacements for the itemized bill.

3. Itemized Bills Must Include:

Employee Name	Provider Name	Date of Service
Patient Name	Provider Address	Diagnosis Code
Type of Service (CPT Code)	Provider Tax ID Number	Charge for Service

4. If you received this claim form electronically, you may fill in the fields by clicking in the field and typing in the information.

5. If you are completing this form by hand, please use a new printed form rather than a photocopy to ensure the form can be scanned into our system. Also, please print clearly and use black ink when completing this form.

6. **Claims must be received within the timely filing provisions of the plan for the claims to be considered payable. Please refer to your Plan Document for additional details on timely filing of claims.**

7. Use a separate claim form for each provider and for each member of the family. A new form may be obtained through your miBenefits account, at ebms.com or by calling a Client Services Representative using the toll-free number on your ID card.

8. To ensure the correct processing of your claim, please provide your ID Number. This can be found on the front of your ID card.

EXPLANATION OF BENEFITS
You will receive an Explanation of Benefits (EOB) after your claim is processed which explains the charges applied to your deductible and any charges you may owe to the provider. Please keep these EOBs for later reference.

SUBMISSION INSTRUCTIONS
If you are submitting claims by mail, please send to:
EBMS, Inc.
P.O. Box 21367
Billings, MT 59104-1367

You may also fax your claim submission to EBMS, Inc. at (406) 652-5380 or

Email to advocate@ebms.com

If you have questions, please contact our Client Service Center at (800) 777-3575 or via our website: www.ebms.com

MEMBER CLAIM SUBMISSION FORM

P.O. Box 21367 Billings, MT 59104-1367
Phone: 800.777.3575 ● Fax: 406.652.5380 ● Website: *www.ebms.com*

This form can be used for all claims from Benefis or a Benefis physician.
This form only needs to be used if the provider is **not** submitting a claim on your behalf.

Please refer to the previous page for instructions.

EMPLOYEE INFORMATION: To be completed by the Employee

Employee Last Name:	First Name:	M.I.:	Date of Birth:

Current Mailing Address:
Street City State Zip

Member I.D. Number:	Phone Number:	Employer Name:

PATIENT INFORMATION: To be completed only if the patient is other than Employee

Patient Name: (First and Last)	Relationship to Employee: ☐Spouse ☐Child ☐Other	Gender: ☐M ☐F	Date of Birth:

Patient Mailing Address: (If different than above)
Street City State Zip

At the time the medical service was provided, was the patient: ☐Employed ☐Full-time Student ☐ N/A

ACCIDENT/OCCUPATIONAL INJURY CLAIM INFORMATION:
Complete only if the claim is a result of an accident or work-related injury

Was the accident/injury due to Employment? ☐ Yes ☐ No	Was the injury due to an auto accident? ☐ Yes ☐ No	Date of injury:

Brief Description of the accident or injury:

Are you or your dependents filing a claim or lawsuit against a third party, including an insurance company, in order to recover the costs of expenses incurred as a result of this accident or illness? ☐ Yes ☐ No

If yes, what is the name of the third party?

FAMILY OR OTHER INSURANCE COVERAGE INFORMATION:
Complete only if the claim is for a dependent and/or other coverage is in effect

Is Spouse employed?: ☐Yes ☐ No	If no, has spouse been employed during last 12 months? : ☐Yes ☐ No	Name of Spouse:	Date of Birth:

Name and Address of Spouse's employer:
Name Street City State Zip

Is the patient covered under another group health plan or Medicare? ☐ Yes ☐ No	If yes, please supply the following: Effective Date of Coverage: Policy Number: Type of Plan: (HMO, PPO, etc.)

If there is other insurance and that insurance is primary, please enclose a copy of the explanation of benefits with this form and the itemized bill.

CERTIFICATION:

Any person who knowingly and with intent to defraud any employee benefit plan, insurance company, or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any material fact thereto, commits a fraudulent act which is a crime.
I certify that the information supplied is true and correct.

Employee's Signature: **Date:**

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS:

I hereby authorize any provider, insurance company, employer or organization to release any information regarding medical, mental, dental, alcohol or drug history, treatment, or benefits payable, including disability or employment related information regarding this claim to EBMS or authorized agents for the purpose of validating and determining benefits payable in connection with this claim. A photo copy of this authorization shall be considered as effective and valid as the original. (The plan will not reimburse any provider charges for this release.)

I authorize payment of medical benefits to the Benefis provider for all services submitted with this claim form.

Employee's Signature: **Date:**