Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, MT 59104-1367

STATEMENT OF CLAIM

Please help us to properly process your claim for benefits under your employer-sponsored health plan by completing this claim form. By filling out this form completely, you will help expedite the payment of your claim. Both the covered person and patient (if over 18) must sign this form. Enclose all bills relating to this claim if you have not already mailed them to us. All bills must show patient's name, dates of service, and an itemization of charges. Prescription bills must show patient's name, prescription name and number, physicians name, and dates of service. Thank you.

Name of Employee__________ Date of Birth __________

Name of Employer__________

Member ID No. __________ Marital Status __________

Home Address __________ City __________ State _____ Zip _____

Is spouse employed? _____ yes   If yes, name of employer __________

_____ no   If no, has spouse been employed during the last 12 months? _____ yes _____ no

Name of employer __________

Do you or any of your family members have other health coverage? _____ yes _____ no

If yes, give the name of the company, address, and policy number __________

____

Complete if this claim is for dependent

Full name of dependent __________

Relationship to covered person __________ Date of birth __________

Is dependent employed? _____ yes _____ no

If yes, where __________

Is dependent a full-time student? _____ yes _____ no

Name and address of school (if dependent is over 18) __________

____

If this claim is the result of an accident (motor vehicle, fall, etc.) or an incident (assault, medical malpractice, etc), please sign the release information below and then complete the reverse side of this claim form.

Type of professional services sought (medical, dental, chiropractic, mental, etc.) __________

Date illness/disorder began __________ Date of first treatment __________

Did illness/disorder occur in the course of employment? _____ yes _____ no

If yes, have you or do you intend to file this claim under Workers Compensation? _____ yes _____ no

AUTHORIZATION TO RELEASE INFORMATION – 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 concerning 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.)

____

Patient Signature (Parent or Guardian if claim is for a minor)   Date

____

Employee Signature – I authorize payment of all benefits for services rendered by the provider to be sent to the provider   Date

____

Employee Signature – I certify that the foregoing information is true and correct   Date

Note:

<u>ACCIDENT/INCIDENT INFORMATION</u> – In order for benefits to be considered, and to avoid having to resubmit the claim, answer all questions in this section, attach a police report (if applicable), an explanation of benefits (if you have other health coverage), and return all requested information within 14 days of receipt of this form.

Type of accident/incident (auto, fall, etc.) ______________________ Date of accident/incident ______________

Where did the accident happen? ____

Describe what happened ____

____

____

If auto accident, name and address of person responsible ____

____

Name and address of motor vehicle insurance carrier of responsible party ____

____

Were any traffic citations issued or arrests made? _______ yes _______ no If yes, to whom ______________________

Nature of citation or arrest ____

Was a police report filed? _______ yes _______ no If yes, please enclose a copy with this claim form.

Is this claim the result of an accident/incident for which you may be eligible to receive compensation from someone else?

yes _______ no _______

Insurance company responsible for payment relating to the accident/incident ______________________

Address ____ Phone ______________

Policy # ______________________ Policy Holder Name ______________________

Does this policy have coverage for payment of medical expenses? _______ yes _______ no Policy $ Limit ______________

Name of other party's insurance company(ies) ____

Address ____ Phone ______________

Policy # ______________________ Policy Holder Name ______________________

Has settlement been made on this accident/incident? _______ yes _______ no Amount $ ______________ Date ______________

Name of attorney representing claimant with respect to the accident/incident ______________________

Address ____ Phone ______________

Any person who knowingly and with intent to defraud any employee benefit plan, insurance company, or other person files a statement 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.