

HEALTH BENEFIT PLAN CLAIMS FORM

A. Plan Member Information

Name _____ Date of Birth _____
 Address _____ Member ID _____

B. Coordination of Benefit Information

Are any expenses being claimed covered by another group insurance plan? No Yes

If yes, I confirm all coverage available under the Group Plan has been claimed, and the expenses below relate only to medical expenses not covered under the Group Plan.

Group Plan member's name _____ Group Plan Provider/Insurer _____ Policy/Plan No. _____

C. Drug Expenses

Patient Name	Relationship to Plan Member			Date of Birth			Children Only		Number of Receipts per patient	Total Amount per patient	Date of Purchase		
	Self	Spouse	Child	D	M	Y	Full time student	Disabled			D	M	Y

D. Other Expenses (Excluding Drugs)

Patient Name	Relationship to Plan Member			Date of Birth			Children Only		Number of Receipts per patient	Total Amount per patient	Date of Visit or Purchase		
	Self	Spouse	Child	D	M	Y	Full time student	Disabled			D	M	Y
Total of all drugs and other expenses -----													

Have you stapled all ORIGINAL receipts to the back of this form?

F. Authorization

I certify that the information given on this form is true, correct and complete to the best of my knowledge. I authorize the release by any health care provider of any information necessary for the administration of this claim.

Plan Member's Signature _____ Date _____