Health Benefit Plan Claims Form

A. Plan Member Information

Name ____ Date of Birth ___________________

Address ____ Member ID ____________________

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B. Coordination of Benefit Information

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

If yes, complete the following information about the person who is the MEMBER under the other plan:

Other member's name ____________________ Cert. No. ____________ Date of birth ____________________

Insurance Company's Name __________________________ Policy/Plan No. ____________________________

C. Drug Expenses

Patient's Usual Name	Relationship to Plan Member			Date of Birth			Children Only		Number of Receipts per patient	Total Amount per patient	Office Use ONLY
	Self	Spouse	Child	D	M	Y	Full time student	Disabled			

D. Other Expenses (Excluding Drugs)

Patient's Usual 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 ______________________