



HEALTH CLAIM FORM
(FOR MEDICAL, MENTAL HEALTH & SUBSTANCE ABUSE SERVICES)

EMPLOYER NAME :			
EMPLOYEE NAME :		LIFETIME BENEFIT SOLUTIONS ID # OR SS #: <i>(ID # can be found on your ID card)</i>	
LAST	FIRST	MI	
PATIENT'S NAME (IF DIFFERENT FROM ABOVE) :			PATIENT'S DATE OF BIRTH
LAST	FIRST	MI	
IS THIS CLAIM THE RESULT OF AN ACCIDENT?			<input type="checkbox"/> Yes <input type="checkbox"/> No
			If "YES," please provide a description of the accident.
ACCIDENT DESCRIPTION:			
ARE YOU OR ANY OF YOUR DEPENDENTS COVERED UNDER ANOTHER PLAN?			<input type="checkbox"/> Yes <input type="checkbox"/> No
			If "YES," please provide the name of the Plan.
IF YES, NAME OF PLAN:			
REMIT PAYMENT TO: <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> PROVIDER			

MAKE SURE ALL ENCLOSED BILLS LIST

- ❖ DATE(S) OF SERVICE
- ❖ ITEMIZED CHARGES ("BALANCE BILL" STATEMENTS CANNOT BE PROCESSED)
- ❖ DIAGNOSIS CODE
- ❖ NDC NUMBERS FOR EACH PRESCRIPTION (IF APPLICABLE)
- ❖ NAME AND TAX ID OF THE PROVIDER RENDERING SERVICE

EMPLOYEE SIGNATURE _____

DATE _____

Please print and return this form with documentation to the address displayed on the back of your benefit ID card for processing.