

MEDICAL / DENTAL CLAIM FORM



P O Box 50190
Sparks, Nevada 89435-0190
(775) 352-6900 P
(775) 770-9363 F

PLEASE CHECK ONE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL	1. COMPLETE THIS FORM 2. ATTACH ITEMIZED BILLS 3. MAIL TO →
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PLEASE FILL OUT THE FOLLOWING INFORMATION

EMPLOYEE NAME		SOCIAL SECURITY # OR CDS ID #		EMPLOYEE BIRTHDATE		PHONE NO.	
MAILING ADDRESS				CITY / STATE		ZIP	
PATIENT NAME (IF OTHER THAN EMPLOYEE)		MALE <input type="checkbox"/>	RELATIONSHIP TO EMPLOYEE		PATIENT BIRTHDATE		IS PATIENT MARRIED? YES <input type="checkbox"/> NO <input type="checkbox"/>
IS PATIENT FULL TIME STUDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		NAME & ADDRESS OF SCHOOL		DATE ACCIDENT OR SICKNESS BEGAN			
IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?				DID ACCIDENT HAPPEN AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>		HAS CLAIM BEEN FILED WITH WORKERS' COMP? YES <input type="checkbox"/> NO <input type="checkbox"/>	
NATURE OF SICKNESS, INJURY OR DIAGNOSIS				PHYSICIAN'S NAME			
NAME OF SPOUSE		BIRTHDATE	IS SPOUSE EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/>		NAME & ADDRESS OF SPOUSE'S EMPLOYER		
ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP HEALTH PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR THE EXPENSES OF THIS CLAIM? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF PLAN PROVIDING BENEFITS.							
POLICYHOLDER: _____				SOCIAL SECURITY # OR ID # _____			
NAME AND ADDRESS: _____				POLICY NO. _____			
				EFFECTIVE DATE: _____			

PATIENT OR PARENT MUST SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify this information provided is correct and true to the best of my knowledge.

X _____
Covered Person Date

IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER(S):
I hereby authorize payment of benefits to any provider of service, otherwise payable to me for service, but not to exceed the reasonable and customary charges for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Covered Person Date

MEDICAL / DENTAL CLAIM FORM



P O Box 50190
Sparks, Nevada 89435-0190
(775) 352-6900 P
(775) 352-7266 F

PLEASE CHECK ONE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL	1. COMPLETE THIS FORM 2. ATTACH ITEMIZED BILLS 3. MAIL TO →
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