

MERITAIN HEALTH

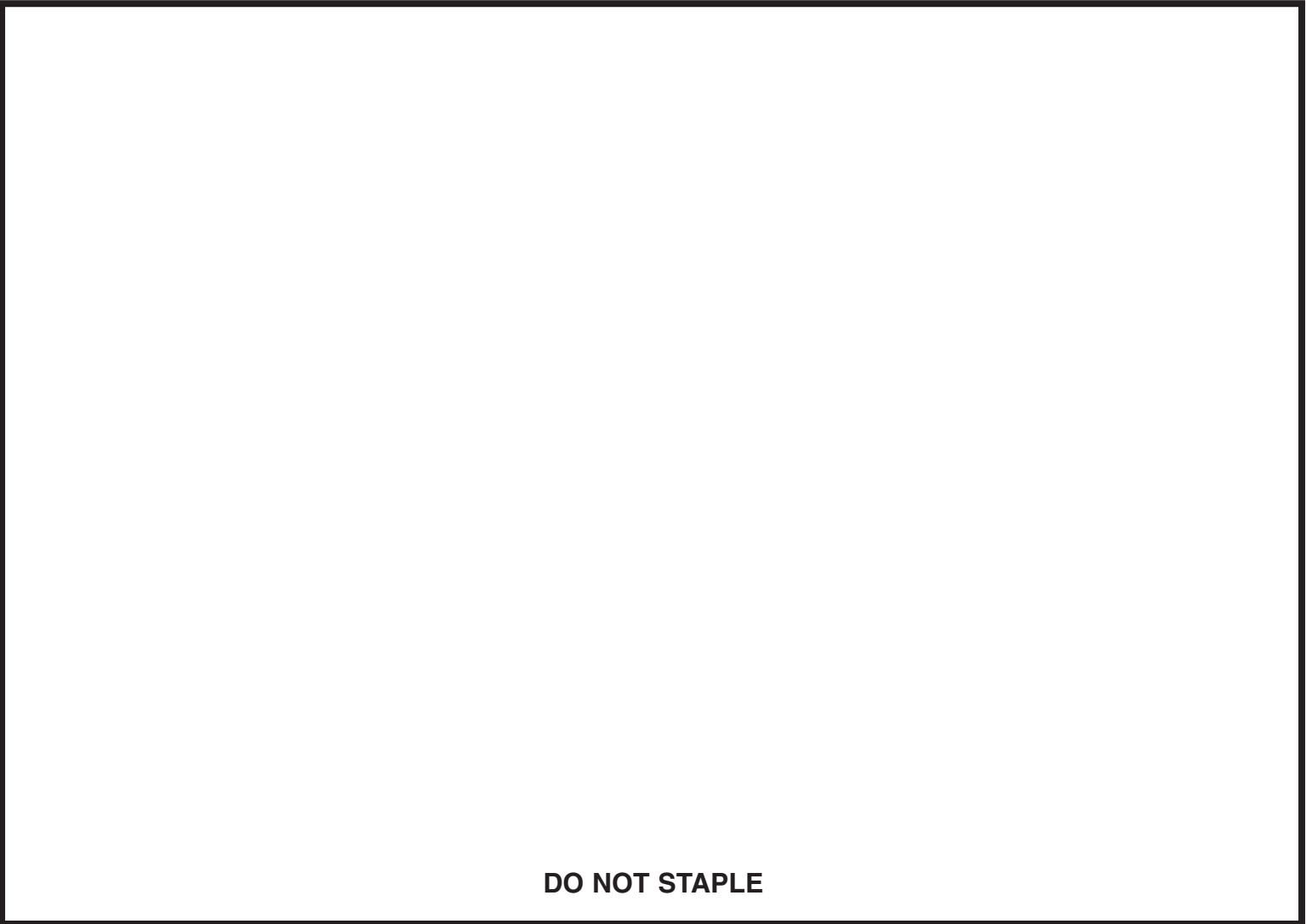
Please submit this form to the address located on the back of your ID Card.

CLAIM FORM

1. EMPLOYER /GROUP NAME/GROUP NUMBER		1a. EMPLOYEE ID NUMBER	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO EMPLOYEE Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY		STATE	
8. NATURE OF ILLNESS OR INJURY. IF INJURY, HOW DID ACCIDENT OCCUR?		7. EMPLOYEE ADDRESS (No., Street)	
CITY		STATE	
ZIP CODE	TELEPHONE (Include Area Code) ()	ZIP CODE	TELEPHONE (Include Area Code)
9. OTHER COVERAGE, INCLUDING MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO EFFECTIVE DATE _____		10. DO YOU WANT TO APPLY UNREIMBURSED EXPENSES TO YOUR HEALTH REIMBURSEMENT ACCOUNT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
11. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. SIGNED _____ DATE _____			

12. ASSIGNMENT: I hereby authorize payment directly to the hospital, physician, dentist or other health care provider herein named of the group benefits payable to me. I understand I am financially responsible for charges not covered by this assignment.
Employee Signature: _____ Date Signed: _____

FOR FASTER PROCESSING, TAPE YOUR BILL(S) HERE OR ON REVERSE SIDE



DO NOT STAPLE