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

# CLAIM FORM

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|---|---|---|
| 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 ☐ F ☐ | 4. EMPLOYEE NAME (Last Name, First Name, Middle Initial) |
| 5. PATIENT'S ADDRESS (No., Street) | 6. PATIENT RELATIONSHIP TO EMPLOYEE Self ☐ Spouse ☐ Child ☐ Other ☐ | 7. EMPLOYEE ADDRESS (No., Street) |
| CITY / STATE | 8. NATURE OF ILLNESS OR INJURY. IF INJURY, HOW DID ACCIDENT OCCUR? | CITY / STATE |
| ZIP CODE / TELEPHONE (Include Area Code) ( ) | | ZIP CODE / TELEPHONE (Include Area Code) |
| 9. OTHER COVERAGE, INCLUDING MEDICARE ☐ YES ☐ NO EFFECTIVE DATE _____ | | 10. DO YOU WANT TO APPLY UNREIMBURSED EXPENSES TO YOUR HEALTH REIMBURSEMENT ACCOUNT? ☐ YES ☐ 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**