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 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

600 (04/02)