Benefit Health Plan, Inc
ADMINISTRATORS
PO Box 1043
Matthews, NC 28106
Phone and Fax: 844-580-2474

MEDICAL CLAIM FORM

Employer Name:_____

EMPLOYEE OR PATIENT: (To be completed in detail by the employee or patient and signed by the employee)			
1. Employee Name		2. Employee Social Security Number	3. Date of Birth Employee Spouse
4. Address of the employee (Street, City, State and Zip)		5. Is this a new address? ☐ YES ☐ NO	6. Work Location of employee
7. Name of Patient	8. Sex ☐ MALE ☐ FEMALE	9. Relationship to Employee ☐ Self ☐ Child ☐ Spouse ☐ Other	10. Marital Status of Patient ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
11. Patient's Social Security Number		12. Patient's Date of Birth	
13. Name of Patient's Employer or School attended		14. Address of Patient's Employer of School attended (Include mailing address, city, state, zip and telephone number)	
15. IS THIS PATIENT COVERED BY ANY OTHER MEDICAL COVERAGE? ☐ YES ☐ NO If Yes, Please Complete Questions #16 – 19. If No, please skip to Question #20.			
16. Name and Address of Other Insurance Company			
17. Name of the Employer, Group or School providing the Plan			
18. Name of the Insured Person			
19. Policy or Certificate Number			
20. I CERTIFY THAT THE STATEMENTS ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. Employee Signature_____			

AUTHORIZATIONS: (TO BE COMPLETED BY THE PATIENT AND EMPLOYEE)	
21. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Hospital or Physician to release information required in the course of my examination or treatment which may be necessary to determine benefits payable under this plan. (A photo static copy of this authorization is as valid as the original.)	SIGNED (PATIENT OR PARENT, IF MINOR) DATE
22. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician and/or Hospital providing services for which benefits are payable. This assignment will be honored only when the claim from the provider of services does not contain any assignment of benefits or an indication that one is on file.	SIGNED (COVERED EMPLOYEE) DATE