

Benefit Claim Form

Please print

SEE REVERSE SIDE FOR INFORMATION ON HOW TO FILE A CLAIM

Employee Information

Last Name	First	MI	Social Security Number
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Patient Information Complete this section only if claim is for a qualified dependent.

Last Name	First	MI	If age 19 or over <input type="checkbox"/> Student <input type="checkbox"/> Disabled If student, give name of school, city and state
Member Number/Suffix	Date of Birth	Relationship	

Accident Information Complete this section only if claim is result of accident or work related illness or injury.

Date of accident or first symptoms of illness?	Where did the accident occur? (City/State)	Is accident/illness related to employment? If no, <input type="checkbox"/> Auto <input type="checkbox"/> Other
Describe the accident or illness.	Give date patient first consulted physician.	Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medicare Information Complete this section only if patient is eligible for Medicare.

Please attach copy of the "Explanation of Benefits" statement from your Medicare Insurance carrier.	Medicare Number	Effective Date Part A	Effective Date Part B
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Other Health Insurance or HMO Coverage If Yes, complete section below or claim cannot be processed. No other coverage

Name of Policyholder	Policy Number	Name of Insurance Company		
Street Address	City	State	Zip	

Authorization/Release of Information

I authorize any insurance company, organization, employer, hospital physician, pharmacist or other health care provider to release any information requested with regard to this claim and the expenses reported. I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to omit facts I know are important.

Patient or authorized person's signature _____ Date _____

I agree to assign benefits directly to the provider of services: _____
Patient or authorized person's signature _____ Date _____

IF DETAIL STATEMENT IS AVAILABLE, PLEASE ATTACH. DO NOT FILL OUT LOWER PORTION.

Provider Statement of Services Rendered

Name and Address of Facility where services were rendered (If other than home or office)		Date Admitted	Date Discharged			
Diagnosis Code and Description 1. 2.						
Date of Service From/To	Place of Service	CPT-4 Procedure Code	Description of Service	Charges	Days or Units	
Signature of Provider				Total Charge	Amount Paid	Balance Due

Provider Name	Tax I.D. Number
Provider Address	Telephone Number

Please mail completed form to:
Southern Health Services, Inc.
P.O. Box 7704
London, KY 40742

HOW TO COMPLETE THIS BENEFIT CLAIM FORM

1. The Employee or Authorized Person must complete the following sections of the Benefit Claim Form:

- Employee Information
- Patient Information
- Accident Information
- Medicare Information
- Other Health Insurance
- Authorization/Release of Information

This claim cannot be processed unless all sections are completed. Claims for services provided by a nonparticipating provider must be submitted on this Benefit Claim Form.

2. Assignment of Benefits

If the provider is **not** a Participating Provider, the decision whether or not to assign benefits is between you and the provider.

3. Submitting the Claim Form

If the provider is **not** a Participating Provider, you are responsible for filing the claim.

Mail the completed Benefit Claim Form to:

Southern Health Services, Inc.

Attn: Claims Department

P.O. Box 7704

London, KY 40742

4. Additional Benefit Claim Forms may be obtained from your employer or by contacting Southern Health Services, Inc.