



BENEFIT MANAGEMENT

S E R V I C E S

MEDICAL CLAIM FORM:

CLAIM FORM

P. O. BOX 98044

BENEFIT MANAGEMENT SERVICES
BATON ROUGE, LA 70898-9044

225-297-2735
1-800-603-2299

EMPLOYEE

EMPLOYEE'S NAME (Please Print)		YOUR DATE OF BIRTH	SOCIAL SECURITY NUMBER	
ADDRESS NO. AND STREET		CITY	STATE	ZIP
OCCUPATION				
WORK STATUS	<input type="checkbox"/> ACTIVE	<input type="checkbox"/> RETIRED	<input type="checkbox"/> TOTALLY DISABLED	MARITAL STATUS
				<input type="checkbox"/> SINGLE
				<input type="checkbox"/> MARRIED
				<input type="checkbox"/> DIVORCED
				<input type="checkbox"/> WIDOWED
DOES EMPLOYEE HAVE OTHER COVERAGE?	IF YES, NAME AND ADDRESS OF OTHER INSURANCE CARRIER			POLICY NUMBER
<input type="checkbox"/> YES	<input type="checkbox"/> NO			

DEPENDENT

SPOUSE'S NAME		SPOUSE'S DATE OF BIRTH	
SPOUSE'S EMPLOYER		ADDRESS OF SPOUSE'S EMPLOYER	
SPOUSE'S WORK STATUS	<input type="checkbox"/> ACTIVE	<input type="checkbox"/> RETIRED	<input type="checkbox"/> TOTALLY DISABLED
COVERAGE TYPE	<input type="checkbox"/> SINGLE	<input type="checkbox"/> FAMILY	<input type="checkbox"/> NONE
GROUP INSURANCE CARRIER			
ADDRESS OF OTHER INSURANCE CARRIER			
IF DIVORCED, WHO HAS CUSTODY OF THE CHILDREN?			
IS THERE A COURT ORDER ASSIGNING FINANCIAL RESPONSIBILITY FOR THE CHILDREN'S MEDICAL EXPENSES?			
IS ANY FAMILY MEMBER ELIGIBLE FOR MEDICARE? IF YES, WHO?			

PATIENT

THIS CLAIM IS FOR	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> NATURAL CHILD	<input type="checkbox"/> STEP CHILD	<input type="checkbox"/> OTHER? SPECIFY _____
PATIENT'S NAME	DATE OF BIRTH		<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	
IF PATIENT IS CHILD 19 YEARS OF AGE OR OLDER, IS HE OR SHE A FULL TIME STUDENT?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	EMPLOYED?
			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
SCHOOL'S NAME AND ADDRESS OR EMPLOYER'S NAME AND ADDRESS					

CLAIM INFORMATION

IS THE ACCIDENT OR ILLNESS JOB-RELATED?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IS CLAIM DUE TO	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> INJURY
IF AN ACCIDENT, WHEN, WHERE AND HOW DID ACCIDENT OCCUR?					

FRAUD STATEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

EMPLOYEE'S SIGNATURE	DATE
AUTHORIZED REPRESENTATIVE	DATE