



**HEALTH CLAIM FORM**

**(FOR MEDICAL, MENTAL HEALTH & SUBSTANCE ABUSE SERVICES)**

<b>EMPLOYER NAME :</b>			
<b>EMPLOYEE NAME :</b>		<b>LIFETIME BENEFIT SOLUTIONS ID #:</b>	
LAST	FIRST	MI	<i>(ID # can be found on your ID card)</i>
<b>PATIENT'S NAME (IF DIFFERENT FROM ABOVE) :</b>			<b>PATIENT'S DATE OF BIRTH</b>
LAST	FIRST	MI	
<b>IS THIS CLAIM THE RESULT OF AN ACCIDENT?</b>			If "YES," please provide a description of the accident.
<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>ACCIDENT DESCRIPTION:</b>			
<b>ARE YOU OR ANY OF YOUR DEPENDENTS COVERED UNDER ANOTHER PLAN?</b>			If "YES," please provide the name of the Plan.
<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>IF YES, NAME OF PLAN:</b>			
<b>REMIT PAYMENT TO:</b>			
<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> PROVIDER			

**MAKE SURE ALL ENCLOSED BILLS LIST**

- ❖ DATE(S) OF SERVICE
- ❖ ITEMIZED CHARGES ("BALANCE BILL" STATEMENTS CANNOT BE PROCESSED)
- ❖ DIAGNOSIS CODE
- ❖ NDC NUMBERS FOR EACH PRESCRIPTION (IF APPLICABLE)
- ❖ NAME AND TAX ID OF THE PROVIDER RENDERING SERVICE

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

**Please print and return this form with documentation to the address displayed on the back of your benefit ID card for processing.**