## **MEDICAL CLAIM FORM**

**MAIL TO:** 

Address Indicated On Your Identification Card



## Instructions:

- 1. Please complete all sections
- 2. All itemized bills MUST be attached and include: Patient's name, Provider's name, diagnosis, dates of services and charge amount.
- **3.** If you or a dependent are covered by another Plan (including Medicare), please submit the bill to the Primary Plan first. Then send our office a copy of the Explanation of Benefits along with the bill.

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EMPLOYEE INFORMATION										
Name (First, MI, Last)					Sex Male Female		rthdate	Mem	ber Number	
Home Address	City				State Zip					
Employer:	Da			ate of Hire			Occupation D		Last Worked	
PATIENT INFORMATION										
Patient Name (First, Middle, Last)			Relation	ıship		Sex Male Female			Birthdate	
		f yes, F Many H		Date Last Attended?  Name and Address of School						
Nature of Illness  Name, Address and Phone No. of Doctor Seen For This Illness										
IF CLAIM IS BASED ON AN ACCIDENT, COMPLETE THE FOLLOWING										
Date and Time of Accident Was Accident Work Related Place How It Happened  Yes No										
SPOUSE INFORMATION										
Name (First, MI, Last)					Sex Male Female		Birthdate	Soc. Sec. No.		
Spouse's Employer Name Address Phone No.									Phone No.	
OTHER INSURANCE INFOR	MATION									
Do You or Your Dependents Have Other Coverage? Yes No Type of Coverage? Single Family			of Plan? Group H	lealth Pl						
	me of Person Covered by Other Insurance Group Number Soc. \$				Ве	enefits Medica	al Dental	Visio	n Other	
Name and Address and Phone No. of Other Insurance Company										
AUTHORIZATION TO RELEASE INFOI I hereby authorize any Dentist, Physicia Company, Organization, or Employer to Luminare Health for any oral or dental of services, or benefits rendered or payabl photocopy of this authorization shall be		Ī	PATIEN'	T'S SIGI	NATURE (	PARENT IF MIN	NOR)	DATE		
AUTHORIZATION TO PAY BENEFITS TO PROVIDERS I hereby authorize payment of benefits to any providers of service rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original				PATIENT'S SIGNATURE (PARENT IF MINOR)  DATE					DATE	