

EBMS

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, MT 59104-1367 U.S.A.

STATEMENT OF CLAIM

High Plains Educational Cooperative #611

Please help us to properly process your claim for benefits under your High Plains Educational Cooperative health plan by completing this claim form. By filling out this form completely, you will help expedite the payment of your claim. Both the covered person and patient (if over 18) must sign this form. Enclose all bills relating to this claim if you have not already mailed them to us. All bills must show patient's name, dates of service, and an itemization of charges. Prescription bills must show patient's name, prescription name and number, physicians name, and dates of service. Thank you.

Name of Employee _____ Date of Birth _____

Soc. Security No. _____ Marital Status _____

Home Address _____ City _____ State _____ Zip _____

Is spouse employed? _____ yes _____ no If yes, name of employer _____

_____ no If no, has spouse been employed during the last 12 months? _____ yes _____ no

Name of employer _____

Do you or any of your family members have other health coverage? _____ yes _____ no

If yes, give the name of the company, address, and policy number _____

Complete if this claim is for dependent

Full name of dependent _____

Relationship to covered person _____ Date of birth _____

Is dependent employed? _____ yes _____ no

If yes, where _____

Is dependent a full-time student? _____ yes _____ no

Name and address of school (if dependent is over 18) _____

If this claim is the result of an accident (motor vehicle, fall, etc.) or an incident (assault, medical malpractice, etc), please sign the release information below and then complete the reverse side of this claim form.

Type of professional services sought (medical, dental, chiropractic, mental, etc.) _____

Date illness/disorder began _____ Date of first treatment _____

Did illness/disorder occur in the course of employment? _____ yes _____ no

If yes, have you or do you intend to file this claim under Workers Compensation? _____ yes _____ no

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any provider, insurance company, employer or organization to release any information regarding medical, mental, dental, alcohol or drug history, treatment, or benefits payable, including disability or employment related information concerning this claim to EBMS or authorized agents for the purpose of validating and determining benefits payable in connection with this claim. A photo copy of this authorization shall be considered as effective and valid as the original. (The plan will not reimburse any provider charges for this release.)

Patient Signature (Parent or Guardian if claim is for a minor) _____ Date _____

Employee Signature – I authorize payment of all benefits for services rendered by the provider to be sent to the provider _____ Date _____

Employee Signature – I certify that the foregoing information is true and correct _____ Date _____

Note:

ACCIDENT/INCIDENT INFORMATION – In order for benefits to be considered, and to avoid having to resubmit the claim, answer all questions in this section, attach a police report (if applicable), an explanation of benefits (if you have other health coverage), and return all requested information within 14 days of receipt of this form.

Type of accident/incident (auto, fall, etc.) _____ Date of accident/incident _____

Where did the accident happen? _____

Describe what happened _____

If auto accident, name and address of person responsible _____

Name and address of motor vehicle insurance carrier of responsible party _____

Were any traffic citations issued or arrests made? _____ yes _____ no If yes, to whom _____

Nature of citation or arrest _____

Was a police report filed? _____ yes _____ no If yes, please enclose a copy with this claim form.

Is this claim the result of an accident/incident for which you may be eligible to receive compensation from someone else?
yes _____ no _____

Insurance company responsible for payment relating to the accident/incident _____

Address _____ Phone _____

Policy # _____ Policy Holder Name _____

Does this policy have coverage for payment of medical expenses? _____ yes _____ no Policy \$ Limit _____

Name of other party's insurance company(ies) _____

Address _____ Phone _____

Policy # _____ Policy Holder Name _____

Has settlement been made on this accident/incident? _____ yes _____ no Amount \$ _____ Date _____

Name of attorney representing claimant with respect to the accident/incident _____

Address _____ Phone _____

Any person who knowingly and with intent to defraud any employee benefit plan, insurance company, or other person files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act which is a crime.