

EMPLOYER PLAN SERVICES, INC.

MEDICAL CLAIM FORM

1. EMPLOYEE SECTION (Always complete this section)	EMPLOYER NAME		GROUP NUMBER			
	EMPLOYEE'S NAME		SOCIAL SECURITY #			
	Address:		City:	State:	Zip:	
	THIS CLAIM IS FOR: <input type="checkbox"/> EMPLOYEE (FILL OUT SECTIONS 3,4,&5) <input type="checkbox"/> DEPENDENT (ANSWER ALL SECTIONS)					
2. ABOUT THE DEPENDENT (Complete only if patient is a dependent)	DEPENDENT'S NAME:	BIRTHDATE:	RELATIONSHIP: <input type="checkbox"/> SPOUSE	S.S. #:		
				<input type="checkbox"/> CHILD <input type="checkbox"/> STPCHILD <input type="checkbox"/> OTHER	<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED
	DEPENDENT'S ADDRESS:			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW (ER)		
	IS DEPENDENT EMPLOYED? ↓ <input type="checkbox"/> NO <input type="checkbox"/> YES ⇨ <input type="checkbox"/> RETIRED	IF EMPLOYED: <input type="checkbox"/> PART-TIME <input type="checkbox"/> FULL-TIME	NAME OF EMPLOYER:			
3. ABOUT THE CLAIM	WERE THERE ANY INJURIES? <input type="checkbox"/> YES ⇨ COMPLETE THIS SECTION <input type="checkbox"/> NO ↓	If "YES", was the injury: <input type="checkbox"/> at home <input type="checkbox"/> other _____ <input type="checkbox"/> at work When did the injury occur? Month _____ Day _____ Year _____ AM _____ PM Give a brief description of how the injury occurred:				
	4. OTHER COVERAGE	Is the patient covered by another group plan? <input type="checkbox"/> YES ⇨ (Complete this section) <input type="checkbox"/> NO ↓	If "YES", name of covered person & Employer: If "YES", name of the insurance carrier or plan:			
5. SIGNATURE		I HEREBY AUTHORIZE ANY INSURANCE CARRIER, PLAN, ORGANIZATION, HOSPITAL EMPLOYER, SURGEON, PHYSICIAN, OR ANESTHETIST TO RELEASE ANY INFORMATION REQUESTED WITH RESPECT OF THIS CLAIM. DATE : _____ 20 _____ SIGNED _____				

Any person who knowingly and with intent to injure, defraud or deceive any benefit plan, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal offense.

PLEASE MAIL THE COMPLETED FORM TO:
 EMPLOYER PLAN SERVICES, INC.
 2180 North Loop West, Suite 400
 Houston, Texas 77018

For Information Please Call:
 EMPLOYER PLAN SERVICE, INC.
 (713) 932-8917
 1-800-447-6588