

MEDICAL CLAIM FORM

HOW TO PRESENT A CLAIM:

- Complete the "Employee Statement" below. A separate form will be required for each illness or accident and each family member.
 To avoid delay be sure to answer all questions.
- 2. Bills submitted for each person must show: (a) name of the patient; (b) type of service rendered; (c) date of service rendered, and (d) the amount of the charge. Bills and receipts for drugs and medicine must show: (a) name of the patient; (b) prescribing physician; (c) prescription number or nature of medication; (d) date of purchase and (e) charge for each prescription.

WHERE TO SEND A CLAIM:

EMPLOYEE'S SIGNATURE

SOUTH POINT BENEFITS 9777 Las Vegas Blvd. South Las Vegas, NV 89183

EMPLOYEE'S NAME		SEX: M	F 🛛		MARITAL S	TATUS	SOCIA	L SEC	URITY	NO.	
Last						e Divorced Widowed			ODAE OEOOTHIT NO		
				☐ Mar	rried Legally	Separated					
EMPLOYEE'S ADDRESS							-	DATE	OF B	IRTH	
Number and Street		City		State		Zip Code		Month	Day	Ye	
EMPLOYER'S NAME AND ADDRI	ESS									1	
SECTION 1. a. Is your spouse emp	loyed?	🗆 Yes 🗆 No	If the answer	to either is	"Yes," please si	now in "Remarks	" the name of	of the ne	rsons	who	
b. If claim is for any ch	nild, is that child employed?	🗆 Yes 🗆 No	are employed,	the date o	f hire and the na	nme and address	of their resp	ective e	mploye	ers.	
SECTION 2.					SECTION	3.					
s patient also covered for benefits by a		- J DI - OL: 140	_			s or injury due, in					
 Other group health insurance of any Group prepayment arrangement prov 	riding for medical care and t	treatment?		Yes □ I		patient's occupat utomobile accide				□ N	
 Coverage of medical care expenses 	provided by a school, or by	Medicare or other			c. Any oth	er type of accide					
	ent agency?		process of the control of	Yes 1	No.						
federal, state, provincial or government. No fault automobile insurance as a re-	esult of injuries sustained in	an automobile accident?		Yes 🗆 I		ove are answered ")	es," give detail	s			
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any hospital, including Veterans' Administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization to release to each other any medical or other information acquired for myself and all of my covered dependents, including benefits paid or payable, concerning this claim or other disability. A photocopy of this authorization shall be as valid as the original.

PATIENT'S SIGNATURE (Parent, if patient is a minor)

DATE