# MEDICAL CLAIM FORM

**HOW TO PRESENT A CLAIM:**

1. 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:**

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

## EMPLOYEE STATEMENT:

| EMPLOYEE'S NAME | | SEX: M ☐ F ☐ | MARITAL STATUS | SOCIAL SECURITY NO. |
|---|---|---|---|---|
| Last | First | Middle | ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Legally Separated | |

| EMPLOYEE'S ADDRESS | | | | DATE OF BIRTH | | |
|---|---|---|---|---|---|---|
| Number and Street | City | State | Zip Code | Month | Day | Year |

EMPLOYER'S NAME AND ADDRESS

SECTION 1.
a. Is your spouse employed? ☐ Yes ☐ No
b. If claim is for any child, is that child employed? ☐ Yes ☐ No

*If the answer to either is "Yes," please show in "Remarks" the name of the persons who are employed, the date of hire and the name and address of their respective employers.*

SECTION 2.
Is patient also covered for benefits by any:
a. Other group health insurance of any kind including Blue Cross and Blue Shield? ☐ Yes ☐ No
b. Group prepayment arrangement providing for medical care and treatment? ☐ Yes ☐ No
c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? ☐ Yes ☐ No
d. No fault automobile insurance as a result of injuries sustained in an automobile accident? ☐ Yes ☐ No

*If any of the above are answered "Yes," please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency.*

SECTION 3.
Was illness or injury due, in any way
a. To the patient's occupation? ☐ Yes ☐ No
b. To an automobile accident? ☐ Yes ☐ No
c. Any other type of accident? ☐ Yes ☐ No

*If any of above are answered "Yes," give details under "Remarks." If accident involved, include date of accident, accident details and extent of injuries.*

**REMARKS:** *(Please indicate which question you are answering by giving section and question number, such as 2a.)*

## DEPENDENT INFORMATION: *(Complete ONLY if patient is a dependent.)*

| DEPENDENT'S NAME | | SEX: M ☐ F ☐ | MARITAL STATUS | DATE OF BIRTH | | |
|---|---|---|---|---|---|---|
| Last | First | Middle | ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Legally Separated | Month | Day | Year |

| RELATIONSHIP | | SPOUSE'S DATE OF BIRTH | | | SPOUSE'S SOCIAL SECURITY NO. |
|---|---|---|---|---|---|
| ☐ Spouse ☐ Child ☐ Other | **IF CLAIM IS FOR DEPENDENT CHILD, PLEASE INDICATE SPOUSE'S DATE OF BIRTH AND SOCIAL SECURITY NUMBER.** | Month | Day | Year | |

IF CLAIM IS FOR DEPENDENT CHILD 19 OR OLDER:

| Is child enrolled as full-time student? ☐ Yes ☐ No | If "Yes," give name and address of school |
|---|---|

*The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, practitioner or other person, 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.*

EMPLOYEE'S SIGNATURE DATE

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