

PO BOX 16327 Lubbock, TX 79490

Benefits Claim Submission

Health - Dental - Vision

Please Print or Type. Attach itemized bills for covered expenses to this form. Bills must show: Patient name, date, type of service, procedure codes, diagnosis, and amount charged. EMPLOYEE INFORMATION.				 A separate claim form must be completed for each covered dependent. Return claim form and itemized bills to HealthSmart Benefit Solutions. 				
EMPLOYEE INFORMATI			1					
Employee Name (Last, First, Middle Initial)			□ Ma				ity No.	
Home Address (Street, City, State, Zip)								Married □ Yes □ No
Group Plan Number Employer Name				Phone Phone Work: Home:				
				Email Address:				
Spouse Name: Is Spouse Employed?					'es □ No If Yes, P	rovide the	e Emplo	yer Name, Address, Phone:
Birthdate:								
PATIENT INFORMATION	J							
Patient Name (Last, First, MI)					Birthdate			☐ Male ☐ Female
Relationship to Employee:	□ Self □ S	Spouse ☐ Child		Does the Patient reside with you on a permanent basis?				
☐ Step-Child ☐ Other:				☐ Ye	s □ No □ N/A - e	mployee	e is the	patient
Does the Patient have other	insurance co	verage? ☐ Yes ☐	No		: If yes, complete i	nformat	tion be	low:
Type of Coverage: ☐ Employer/Group ☐ Individual ☐ Other:			Group	up and/or Policy No. Effective Date			tive Date	
				Insurance Company Name, Address, Phone				
la de a Dadiana Diaghta do El V	/ N-	If Yes, please provide	de date	e(s) (MI	M/DD/YY) below:			
Is the Patient Disabled?	Yes ⊔ No	Date Last Worked:			Disabled From:			To:
CLAIM INFORMATION								
CLAIM INFORMATION This is a claim for: □ Me	edical 🗆 D	ental □ Vision	Rea	ason fo	r claim: 🗆 Illness 🗆	Accide	nt 🗆 O	Other:
This is a claim for: ☐ Me	n accident, c	omplete the items	below	and su	bmit an Accident/I			
This is a claim for: Me NOTE: If claim is due to ar Go to <a fore-4"="" href="http://maa-tpa.com/forman-repa.com/form</td><td>n accident, c</td><td>omplete the items the instructions to co</td><td>below
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This is a claim for: NOTE: If claim is due to ar Go to http://maa-tpa.com/for/ Accident related to: Work? IDate and place of accident? AUTHORIZATION - PLE I authorize any physician, decompany, government agency and records relating to a diagor my dependents. I understother persons or organization I may further authorize. I he that medical benefits paid un such benefits paid) from any above. A photocopy of this a	ASE READ entist, medical cy or consuming reby acknowledge the plan of payments, and thorization relization upon remarks and remarks and the plan of payments, and thorization relization upon remarks.	CAREFULLY. practitioner, hospitaler reporting agency stall history, physical conformation obtained business or legal stall history and the mains or settlement emains valid for the request. JTHORIZED FOR RESEASES SUCH AS	below omplete //es □ N al, clinicate disclor ment di will no ervices al plan my pers si which term of the ELEAS. BLE DHEPAT	c, pharrose to cal concept be rein concept be	macy or any other properties of the accordance o	pident: Didiction or any or or are to be arty becarvoked by DS WHI NEREA	f health his or mother in anizatio as manent pro- e reimb ause of y me in	care, any insurance y employer all information of the injury described writing. I have a right to the tase, which may be a required by law, or as a covision which provides ursed (up to the amount of the injury described writing. I have a right to the tase, which may be a right to the tase, which may be a right to the tase, which may be a right to the tase.
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Form No. 6-HS OKC 2/2014