HealthSmart

PO BOX 16327 Lubbock, TX 79490

Benefits Claim Submission

Health – Dental - Vision

Instructions

1. Please Print or Type.
2. Attach itemized bills for covered expenses to this form.
   a. Bills must show: Patient name, date, type of service, procedure codes, diagnosis, and amount charged.
3. A separate claim form must be completed for each covered dependent.
4. Return claim form and itemized bills to HealthSmart Benefit Solutions.

EMPLOYEE INFORMATION

Employee Name (Last, First, Middle Initial)	☐ Male ☐ Female	Birthdate	Social Security No.
Home Address (Street, City, State, Zip)			Married ☐ Yes ☐ No
Group Plan Number	Employer Name	Phone Work:	Phone Home:
		Email Address:	
Spouse Name: Birthdate:	Is Spouse Employed? ☐ Yes ☐ No If Yes, Provide the Employer Name, Address, Phone:		

PATIENT INFORMATION

Patient Name (Last, First, MI)	Birthdate	☐ Male ☐ Female
Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other:	Does the Patient reside with you on a permanent basis? ☐ Yes ☐ No ☐ N/A - employee is the patient	
Does the Patient have other insurance coverage? ☐ Yes ☐ No	**NOTE: If yes, complete information below:**	
Type of Coverage: ☐ Employer/Group ☐ Individual ☐ Other:	Group and/or Policy No.	Effective Date
☐ Medical ☐ Dental ☐ Vision ☐ Medicare ☐ Medicaid ☐ Other:	Insurance Company Name, Address, Phone	
Is the Patient Disabled? ☐ Yes ☐ No	If Yes, please provide date(s) (MM/DD/YY) below:	
	Date Last Worked:	Disabled From: To:

CLAIM INFORMATION

This is a claim for: ☐ Medical ☐ Dental ☐ Vision

Reason for claim: ☐ Illness ☐ Accident ☐ Other:

NOTE: If claim is due to an accident, complete the items below and submit an Accident/Injury Questionnaire.
Go to http://maa-tpa.com/forms and read the instructions to complete the questionnaire.

Accident related to: Work? ☐ Yes ☐ No Motor Vehicle? ☐ Yes ☐ No
Date and place of accident?

Briefly describe the accident:

AUTHORIZATION - PLEASE READ CAREFULLY.

I authorize any physician, dentist, medical practitioner, hospital, clinic, pharmacy or any other provider of health care, any insurance company, government agency or consumer reporting agency to disclose to HealthSmart Benefit Solutions or my employer all information and records relating to a diagnosis, medical history, physical or mental condition and evaluation, or any other information relating to me or my dependents. I understand that any information obtained will not be released to any person or organization except its reinsurers, other persons or organizations performing business or legal services in connection with my coverage, or as may be required by law, or as I may further authorize. I hereby acknowledge that my medical plan has a Subrogation and Reimbursement provision which provides that medical benefits paid under the plan on behalf of me or any person covered under my plan are to be reimbursed (up to the amount of such benefits paid) from any payments, awards, or settlements which may be paid by another party because of the injury described above. A photocopy of this authorization remains valid for the term of coverage unless earlier revoked by me in writing. I have a right to receive a copy of this authorization upon request.

I UNDERSTAND THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE INCLUDING A VENEREAL DISEASE, WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) OR AIDS RELATED COMPLEX (ARC).

I release anyone providing this information from all legal responsibility or liability that may arise from this Authorization.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

Dependent Age 18 and over, must sign authorization:

Dependent Signature _____ Date _____

Any person who knowingly, and with intent to injure, defraud, deceive, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.