

# GROUP HEALTH CLAIM FORM

**GROUP NAME** \_\_\_\_\_ **GROUP NUMBER** \_\_\_\_\_

Claim submitted with completed Group Health Claim Form is for:  Employee  Spouse  Dependent

**PLEASE COMPLETE FORM COMPLETELY. A GROUP HEALTH CLAIM FORM MUST BE COMPLETED FOR EACH CLAIM SUBMITTED. ATTACH ALL BILLS/CORRESPONDENCE IF YOUR PHYSICIAN IS NOT FILING THE CLAIM FOR YOU. IF CLAIM IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THE OTHER INFORMATION SECTION OF THIS FORM.**

**EMPLOYEE'S INFORMATION**

Employee Name _____	Date of Birth _____
Social Security Number _____	Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
Are you presently employed? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give name and address of employer _____
If not presently employed, please check which apply: <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	_____ _____

**SPOUSE'S INFORMATION**

Spouse Name _____	Date of Birth _____
Social Security Number _____	Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
Are you presently employed? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give name and address of employer _____
If not presently employed, please check which apply: <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	_____ _____

**DEPENDENT INFORMATION**

Dependent Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Gender (circle one)	Full-Time* Student (if over age 18)	Disabled**
			Male / Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Please provide a copy of proof of full-time student status (i.e. Student Transcript, Class Schedule, Letter from Registrar.)

\*\* Please provide Physician's Statement for proof of disability.

**ADDITIONAL INFORMATION**

Is the patient covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following information:  Insured Name _____  Insured Company Name _____  Policy Number _____  Policy Effective Date _____	Place, Date, and Description of Accident/Remarks: _____ _____ _____ _____ _____
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**AUTHORIZATION FOR RELEASE OF INFORMATION**

**TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, EMPLOYERS, AND OTHER PERSONS OR INSTITUTIONS.** This authorizes you to give WEB-TPA, or its authorized representative who is employed to assist in the evaluation of my claim, any information, date or records you may have regarding me, my employment or my condition (including records pertaining to psychiatric, drug or alcohol use history, and any disability I may have had). I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to an agency or person employed by WEB-TPA. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photocopy of this authorization may be accepted as effective and valid as the original. By signing, this form, I submit my annual information review and initial claim authorization. I understand that claims submitted under this authorization will be processed subject to continued proof of eligibility and all plan provisions. I verify that the information on the entire form is correct.

Patient/Authorized Person's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employee's Mailing Address \_\_\_\_\_  
Street City State Zip