



Claim Request Form

I. General Information

Member's Name: _____

Home Address: _____

City, State, Zip Code: _____

Home Phone: _____

Work/Cell Phone: _____

Email Address: _____

II. Claim Information:

Patient's Name: _____

Patient's Date of Birth: _____

Member ID or Social Security Number: _____

Date of Service: _____

Provider's Name: _____

Amount of Claim: _____

Please provide a brief description of the claim. If claim is for an Emergency visit, please provide a brief explanation of the event. _____
