

Claim Form

Submit completed form to:

P.O. Box 7777 Lancaster, Pennsylvania 17604-7777 Fax 717-581-8379



COMPLETE FOR ALL CLAIMS - Please print

Employee Name _____

Home Address _____

Group # _____ Member ID # _____ / _____ / _____ Daytime Tel. # (____) _____

Are you: Single Divorced Widowed Married If Married, Spouse's Date of Birth: _____ / _____ / _____
Month / Day / Year

PATIENT INFORMATION

Claim is for: You (Employee) If checked, go to next Section Dependent If checked, complete below

Name: _____ Relationship: Spouse Child Birthdate: _____ / _____ / _____
Month / Day / Year

Status: Married Single Separated Divorced Full-Time Student (age 19 or older)*

*Name and Address of School (if applicable under your plan): _____

ACCIDENT AND INJURY INFORMATION

Type: Auto Work Related Other Date of Accident: _____ Date Treated: _____

Description of Accident: (Where, When and How did it Happen): _____

Was another party responsible for the injury? Yes No If yes, complete the following -

Name and Address of Other Party: _____

Name and Address of Other Insurance Company(ies) involved: _____

Name and Address of your Attorney (if you have retained one): _____

Name and Address of Police Station (if a police report was filed): _____

Attach copies of police reports, accident forms or claims submitted to other insurance carriers.

AUTHORIZATION TO PAY BENEFITS Pay doctor/hospital directly If checked, you authorize payment to go directly to the doctor or hospital or to a participating/panel provider. You have paid the bill.

OTHER MEDICAL BENEFITS/HEALTH INSURANCE

Are you, your spouse or dependents also covered for medical benefits through any other employer, welfare plan or Medicare? Yes No If "Yes", complete the following. If "No" go to the next Section.

Attach the itemized bill along with a copy of the Explanation of Benefits (EOB). If an EOB from the other plan or Medicare is not available, please provide the name and address of the company providing benefits:

Name of Person Covered: _____ Social Security Number: _____ / _____ / _____

Relationship: Self Spouse Child Surviving Spouse Other (Please Specify): _____

Is Spouse or Dependent also employed? Yes No If "Yes", Employer Name: _____

EMPLOYEE CERTIFICATION (Must be signed by dependent (if not a minor) if this is their claim.)

Notice: Any person who knowingly and with intent to defraud any insurance company or plan, files a statement of claim containing any materially false information or conceals information for the purpose of misleading, *commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

Employee Signature: _____ Date: _____

Dependent Signature (if needed): _____