

Health Claim Form



Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Email: mnsca@meritain.com
Fax: 1.763.852.5057
Please retain your fax confirmation.

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on the bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

Section 1. EMPLOYEE INFORMATION					
Name (last, first, initial)			Sex	Employer Name Archdiocese of Atlanta	
Home Address			Identification Number	Birthdate	Group Number
City	State	Zip Code	Work Telephone ()		Home Telephone ()
Section 2. PATIENT INFORMATION					
The patient is:	<input type="checkbox"/> The employee (Go to section 3)	<input type="checkbox"/> Employee's Spouse (Complete spouse information)	<input type="checkbox"/> Employee's Child (Complete spouse and child information)		
Spouse's Name (last, first, initial)		Sex	Child's Name (first, last, initial)		Sex
Spouse's Birthdate	Spouse's Social Security Number		Child's Birthdate	Child's Social Security Number	
Spouse's Employer					
Spouse's Employer's Address					
Section 3. OTHER COVERAGE					
<input type="checkbox"/> Yes (then complete) <input type="checkbox"/> No (go to section 4)			Name of Policy Holder:		
Name of Other Health Insurance Carrier or Plan		Address		City	State Zip Code
Other Insurance Carrier's or Plan's Telephone #	Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual		Group Number	Contract or Policy Number	
Spouse's Employer					
Spouse's Employer's Address					
Section 4. ABOUT THIS CLAIM					
<input type="checkbox"/> Injury <input type="checkbox"/> Illness		Describe injury, when and how it happened or nature of illness:			
Date and time of accident:					
Was this injury the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If auto insurance was involved, please provide:			Policy #	Name of insurance company	Address (city, state, zip)
Was this a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			If injury is work-related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.		
EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED					
The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.					
Signature:				Date:	
ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)					
I authorize payment of benefits to the doctor or supplier of services listed here.					
Provider to be paid			Employee's Signature		
Provider's tax ID number or Social Security Number			Date		