Medical Claim Reimbursement Form

GROUP NAME: _____ **GROUP #** _____

STATEMENT OF CLAIM FOR GROUP HEALTH BENEFITS	MAIL THIS FORM TO: EBPA P.O. Box 2000, Exeter, NH 03833-2000 (603) 778-7106 or (800) 578-3272

All claims should be filed immediately upon receipt. Late filing for benefits may result in denial of payment.

How to file a claim: Complete this claim form, attach the providers diagnostic bill and/or prescription receipt mail to **EBPA**.

EMPLOYEE	Name of Employee: _____ Date of Birth: _____ Participant ID #: _____
PATIENT	Name of Patient: _____ Date of Birth: _____ Is Patient Covered By Any Other Medical Insurance Plan? ☐YES ☐NO
PROVIDER	Provider Name: _____ Provider Address: _____ Provider Phone #: _____
NATURE OF CLAIM	1. An Accident? ☐YES ☐NO Nature of Injury: _____ 2. An Illness? ☐YES ☐NO Nature of Illness: _____ 3. Routine Physical? ☐YES ☐NO
INFORMATION AUTHORIZATION	I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon or pharmacy to release any information requested by Employee Benefit Plan Administration (EBPA) or its representatives. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that EBPA will use the information obtained by this authorization to determine eligibility for coverage and benefits. To the best of my knowledge and belief, the above information is true and accurate. Signature _____ Date _____