# EBPA Medical Claim Reimbursement Form

**GROUP NAME: _____ GROUP #: _____**

| | |
|---|---|
| STATEMENT OF CLAIM FOR GROUP HEALTH BENEFITS | MAIL THIS FORM TO:<br>EBPA P.O. Box 2000, Exeter, NH 03833-2000<br>(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: _____<br>Date of Birth: _____<br>Participant ID #: _____ |
| **PATIENT** | Name of Patient: _____<br>Date of Birth: _____<br>Is Patient Covered By Any Other Medical Insurance Plan? ☐YES ☐NO |
| **PROVIDER** | Provider Name: _____<br>Provider Address: _____<br>Provider Phone #: _____ |
| **NATURE OF CLAIM** | 1. An Accident? ☐YES ☐NO<br>Nature of Injury: _____<br>2. An Illness? ☐YES ☐NO<br>Nature of Illness: _____<br>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.<br><br>Signature Date |