SELF INSURED SERVICES CO.

CLAIMANT ID FORM

Complete all sections and attach a bill from your Health Care Provider. Note: The bill must include charges, date of service, diagnosis, procedure code(s) and the Tax ID number of your provider.

Name of Employer _____ **Group Plan #** _____

SECTION I – Employee Information

Name _____ Birth Date _____
First Middle Last

Address _____
Number Street City State Zip

Married Widowed
Single Divorced
Legally Separated

Social Security Number _____ - _____ - _____

SECTION II – Patient Information

Male Employee
Patient's Name _____ Female Spouse
Child

Patient's birth date
_____/_____/_____

Social Security Number
_____/_____/_____

Full-time student
Yes No

Date of enrollment
_____/_____/_____

If a full-time student, name and address of school:

If patient is employed, list name and address of patient's employer:

SECTION III – Other Coverage

- Is patient covered by any other Plan? Yes No
- Any group insurance, union, welfare, HMO coverage, Medicare coverage, or any arrangement of coverage for individuals in a group? Yes No
- Blue Cross, Blue Shield or any other prepayment arrangement on a group basis? Yes No
- Any other coverage provided by an employer, school or any Federal, state or other governmental agency? Yes No
- No Fault Automobile insurance as a result of injuries sustained in an automobile accident? Yes No
- If any of the above are answered "Yes", please indicate in "*remarks*" the policy number, insurance company, and the name and address of the school, employer, union, or governmental agency.

Remarks

SECTION IV – Assignment of Benefits

I hereby authorize payment directly to the physician and/or hospital who provided services for which benefits are payable, but not to exceed the reasonable and customary charge.

Employee's Signature _____ Date _____

SECTION V – Authorization to Release Information

I hereby authorize all physicians, hospitals, druggists, and all other agencies including other health plan administrators to furnish to Self Insured Services Co. (SISCO) or the employer full information pertaining to my medical care and expenses.

Patient's signature (or parent, if patient is a minor) _____ Date _____