AmeriBen / IEC Group

PO BOX 7186
BOISE ID 83707
800-786-7930
www.myameriben.com

CLAIM FORM

Patient Information

1. Patient's Name (First, Middle Initial, Last)	2. Patient's Date of Birth	3. Patient's Address (Street, City, State, Zip Code)

4. Patient's Gender ☐Male ☐Female	5. Was condition related to: a. Patient's employment ☐ Yes ☐ No b. An auto accident ☐ Yes ☐ No c. Other type of accident ☐ Yes ☐ No

6. Patient's Relationship to Employee
☐ Self ☐Spouse ☐ Child ☐ Other _____

7. Nature of Injury (Please provide details of the accident or injury (how, when, where) Use the back of this page if additional room is needed.)

Subscriber or Policyholder Information

8. Subscriber's Name (First, Middle Initial, Last)	9. Subscriber's Social Security Number or ID Number	10. Subscriber's Address (Street, City, State, Zip Code)

11. Subscriber's Group Number	12. Subscriber's Group Name

13. Is there other Medical ☐ Dental ☐ Vision ☐ Coverage (other than listed above)?
☐ No ☐ Yes **(If yes, please provide the following information.)**

Policyholder Name: _____ **Policyholder Social Security Number:** _____

Group Number: _____ **Effective Date of Policy:** _____

Name and address of the insurance company: _____
_____
_____
_____

14. Patient's or authorized person's signature **I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing any time, provided that I do so in writing, except to the extent that the action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire one (1) year from the date of signing.** **Please sign here:**	**Date**
15. Subscriber's or authorized person's signature **I authorize payment of medical benefits to the physician or supplier of services. I understand that I may revoke this authorization in writing any time, provided that I do so in writing, except to the extent that the action has been taken in reliance upon this authorization.** **Please sign here:**	**Date**

By signing above, I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse AmeriBen/IEC to the extent of any overpayment which is in excess of the amounts payable under the benefit plan administered by AmeriBen/IEC.

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

1. Complete the Claim Form on the opposite side.
    - Use one Claim Form per family member submitting a claim.
    - Make sure you complete all questions.
    - It is important to know when, how, and where your accident, illness or disability began especially if it is job related.
    - Questions regarding other coverage you or your dependents are eligible for must be answered.
    - Patient or parent (if patient is minor) must always sign item #14, "I authorize the release of any medical information necessary to process this claim."
    - If payment is to be made to provider you must sign item #15.

2. If you have other coverage, (include Medicare or CHAMPUS), make sure you attach all payment statements or declination letters.

3. Attach all medical bills relating to claim.
    - Make sure all bills identify patient.
    - All bills should show date of treatment, type of service, and amount of charges.

4. Mail claims to: **AmeriBen / IEC Group**
   PO Box 7186
   Boise, ID 83707