

PLEASE SUBMIT ALL CLAIMS TO:
P.O. Box 89472
Cleveland, Ohio 44101-6472

HEALTH CARE CLAIM FORM

EMPLOYEE HEALTH PLAN

NOTICE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application for coverages or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.

For **ALL** claims—this area must be filled out completely

E M P L O Y E E	Employee's Name (Please Print Full Name) Last First Middle Initial			Employee's ID Number	
	Address			Marital Status: (check one)	
	City State Zip			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	If this is a new address, contact your employer's personnel office to make the appropriate changes			Name of Spouse: Is your spouse employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee's Date of Birth Month / Day / Year			Name and address of Company where spouse is employed:		

If the patient is a dependent, please complete all of the following. If the patient is the employee, go directly to the area below

P A T I E N T I N F O R M A T I O N	Patient's Name (if other than employee) Last First Middle		
	Patient's Date of Birth Month / Day / Year		Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child
	Date accident occurred or sickness began Month / Day / Year		Description of injury or sickness
	Place of accident (check one) <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other _____		If accident, date and how it occurred
	Is Patient Covered by Another Plan? Any Group Insurance, Blue Cross-Blue Shield or any other pre-payment arrangement maintained on a group basis?		Was injury due, in any way, to patient's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Any other coverage provided by an employer or any federal state of other governmental agency?		If yes, Explain:
	If eligible, is person enrolled in: Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of Part A is _____ Medicare Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of Part B is _____		

R E L E A S E	AUTHORIZATION TO RELEASE INFORMATION —I hereby authorize any physician, hospital, clinic, dispensary, sanitarium, druggist, or any other Provider (including other insurance companies), Employer or Organization to release any information or view a copy of my records pertaining to the examination, treatment, history, prescriptions or medical expenses to Antares Management Solutions or its representatives, for the purpose of validating and determining benefits payable in connection with the claim.	
	_____ PATIENTS SIGNATURE (Parent or Guardian if Claim is on a Minor) DATE	
By my signature, I acknowledge that payment of this claim is subject to the Plan's rights of subrogation and reimbursement, and to the coordination of benefits with any other coverage that the patient may have. Furthermore, I certify that the forgoing information is true and correct.		

P A Y M E N T	PAYMENT AUTHORIZATION —If you participate in a Preferred Provider benefit plan design, your provider should not require you to pre-pay for services covered under you employers' health care benefit plan. Make sure the provider's office is aware that you participate in a Preferred Provider plan and present them with your plan identification card.	
	I hereby authorize payment of these benefits be sent directly to: <input type="checkbox"/> PROVIDER OF SERVICE <input type="checkbox"/> EMPLOYEE (attach proof of payment)	
_____ EMPLOYEES SIGNATURE DATE		

IMPORTANT: CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED.

Do not send this form through your employer. **ATTACH PROVIDER BILLING.**

If you require assistance in presenting this claim, call Customer Service at: 1-800-451-7929.