CLAIM FORM

1. COMPLETE THIS FORM IN FULL AND SIGN BELOW.
2. ATTACH ALL BILLS.
3. MAIL TO:

PO BOX 290396
TAMPA FL, 33687

Fringe Benefits Coordinators, Inc.
An Advanced Benefits Technologies Company

FRINGE BENEFIT COORDINATORS

PO BOX 290396
TAMPA FL, 33687
(833) 236-3229 Fax (352) 372-9805

PART 1 EMPLOYEE / SUBSCRIBER SECTION — PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME	SOCIAL SECURITY #	NAME OF EMPLOYER	
EMPLOYEE MAILING ADDRESS	EMPLOYEE BIRTH DATE	OCCUPATION	GROUP NUMBER _____
CITY STATE ZIP	PHONE NO.	EMAIL ADDRESS	Claims Submission Date

PART 2 PATIENT INFORMATION

PATIENT'S NAME	BIRTH DATE OF PATIENT	RELATIONSHIP TO MEMBER
		SELF ☐ SPOUSE ☐ CHILD ☐

FIRST VISIT DATE	PLACE OF TREATMENT	RECIEPTS / ITEMIZED STATEMENT ENCLOSED	HOW MANY?	PATIENT'S MEDICAL ID NUMBER
	OFFICE ☐ OTHER ☐ _____	☐ NO ☐ YES		

Name and Address of Physician (i.e, Doctor office, Clinic, Hospital)	Reason for doctor visit

PATIENT OR PARENT MUST SIGN AND DATE BELOW

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.

X_____
Patient, or Parent if minor Date

IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):
I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X_____
Employee Date

PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "Employee Statement" section of the form (Part #1).
   - Questions regarding other coverage you or your dependents are eligible for must be answered.
   - Patient, or parent if minor, must always sign the "Authorization to Release Information". A claim cannot be processed without this authorization and verification.
   - If payment is to be made to the provider of services, you should sign that section.

2. **When not accompanied by an itemized bill** have your doctor complete PART 3 for each claim

3. Attach all itemized bills relating to the claim to PART 2 of the Claim Form.
   - Make sure all bills identify the patient.
   - All bills should show the date of treatment, type of service, and amount of charges.

4. If you have other coverage (including Medicare), make sure you attach all Payment Statements, Explanations of Benefits or declination letters.

PART 3 PHYSICIAN'S SECTION

Date first consulted for this condition? _____

Name of Referring Physician (e.g., Public Health Agency)	TAX I.D. # or SSN	If an Emergency check here ☐ Emergency
Physician Facility Address	PHONE NUMBER	
CITY STATE ZIP CODE		

For services related to hospitalization give hospitalization dates Admitted _____ Discharged _____ Diagnosis or nature of illness or injury (Please indicate primary and secondary	PATIENT ACCOUNT #

IS TREATMENT THE RESULT OF ILLNESS OR ACCIDENTAL INJURY? ☐ YES ☐ NO WORK RELATED? ☐ YES ☐ NO	NAME OF REFERRING PHYSICIAN (e.g., Public Health Agency)

PROCEDURES, MEDICAL SERVICES , SUPPLIES FURNISHED

Date of Service	Place of Service	Description of Service	Procedure Code	Type of Service	Charges	Days or Units	Diagnosis Code

PHYSICIAN'S SIGNATURE X _____ DATE _____

PHYSICIAN'S STAMP