Bas
Benefit Administrative Systems, LLC

# MEDICAL CLAIM FORM

*Receipt and itemized statement must be submitted with claim form for reimbursement*

*Mail Completed Form To:*
The address on the back of your ID card under "Claims Submission"

**Questions?** ***Visit us @ www.BAShealth.com or call***
**Members 800-843-3831**
**Providers 877-625-0205**

## EMPLOYEE & EMPLOYER INFORMATION

**Employer Name:** _____ **Group #:** _____ **Member ID#:**_____

**Employee Name:** _____ **Home Phone:** _____ **Work Phone:** _____

**Employee Address:**_____ **Employee Date of Birth:** / /

**Employee Status:** ☐ Active ☐ Retired ☐ COBRA ☐ Leave of Absence

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

## PATIENT AND CLAIM INFORMATION

**Patient's Name:** _____ **Date of Birth:** / / **Gender:** ☐ Male ☐ Female

**Patient Address:**_____

**Patient's Relationship to the Insured:** ☐ Self ☐ Child ☐ Spouse ☐ Stepchild ☐ Other _____

## ACCIDENT/OCCUPATIONAL CLAIM INFORMATION

**Was condition related to Patient's Employment?** ☐ Yes ☐ No **Due to an Accident?** ☐ Yes ☐ No

**Date of Accident or Beginning of Illness:** / /

**Description of how accident or work related illness/injury occurred:**_____

**Are you or your dependents filing a claim or lawsuit against a third party including an insurance company in order to recover the costs incurred as a result of this accident or illness?** ☐ Yes ☐ No

**If yes, Name & Address of Third Party:** _____

## FAMILY/OTHER COVERAGE INFORMATION

**Is your spouse employed?** ☐ Yes ☐ No **If no, has spouse been employed during last 12 months?** ☐ Yes ☐ No

**Name of spouse:** _____ **Spouse's Date of Birth:** / /

**Name & Address of Spouse's Employer:** _____

**Is the patient covered under any other group insurance plan?** ☐ Yes ☐ No **If yes, effective date of coverage:** / /

**Name & Address Health Insurance Company:** _____

**Policy#:**_____ **Member ID #:**_____ **Phone #:**_____ **Type: (Medical/Dental)**_____

**Is the patient covered under Medicare?** Yes No **If yes, effective date of coverage:** / /

## CERTIFICATION

**I certify that the information supplied is true and correct and that the bills attached were incurred by the patient listed above.**

**Employee's Signature** _____ **Date:** / /

## AUTHORIZATION FOR RELEASE OF RECORDS

**I authorize any physician, hospital, any medical service organization, any insurance company or other institution or organization to release to each other any medical or other information acquired, concerning this or other disabilities. A Photocopy of this authorization shall be as valid as the original.**

**Employee's Signature** _____ **Date:** / /

## AUTHORIZATION TO PAY BENEFITS TO PROVIDER

**I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s).**

**Employee's Signature** _____ **Date:** / /