

P.O. Box 7186  
 Boise, ID 83707  
 Phone (208) 344-7900  
 Toll Free (800) 786-7930  
 www.myameriben.com

**Medical Claim Form**

Patient Information				
<b>1. Patient's Name</b> (First, Middle Initial, Last)	<b>2. Patient's Date of Birth</b> ____/____/____	<b>3. Patient's Address</b> (Street, City, State, Zip Code)		
<b>4. Patient's Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>5. Was condition related to:</b> a. Patient's employment <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you filed for Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		b. An auto accident <input type="checkbox"/> Yes <input type="checkbox"/> No c. Other type of accident <input type="checkbox"/> Yes <input type="checkbox"/> No If yes explain, _____
<b>6. Patient's Relationship to Employee</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		<b>7. Nature of Injury</b> (Please provide details of the accident or injury [how, when, where]. Use the back of this page if additional room is needed.)		
<b>8. If condition was related to an accident and a police report was filed, please attach that report to this form.</b>				
<b>9. Where was the service to the patient rendered:</b> <input type="checkbox"/> Physician Office <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Ambulance <input type="checkbox"/> Medical Equipment Supplier <input type="checkbox"/> Pharmacy <input type="checkbox"/> Laboratory <input type="checkbox"/> Other _____				
<b>10. Bills must be itemized.</b> Each itemized bill must include: <input type="checkbox"/> Name and address of provider <input type="checkbox"/> Amount charged for each service <input type="checkbox"/> Name of patient <input type="checkbox"/> Diagnosis code <input type="checkbox"/> Tax ID <input type="checkbox"/> Service Provided <input type="checkbox"/> Procedure code <input type="checkbox"/> Date of service				
<b>Date of Service</b>	<b>Diagnosis Code</b>	<b>Procedure Code</b>	<b>Tax ID</b>	<b>Amount</b>

Subscriber or Policyholder Information		
<b>11. Subscriber's Name</b> (First, Middle Initial, Last)	<b>12. Subscriber's ID Number</b>	<b>13. Subscriber's Address</b> (Street, City, State, Zip Code)
<b>14. Subscriber's Date of Birth</b> ____/____/____	<b>15. Subscriber's Group Number</b> VPO01	<b>16. Subscriber's Group Name</b> APEHP
<b>17. Is there other <span style="color: red;">Medical</span> <input type="checkbox"/> <span style="color: red;">Dental</span> <input type="checkbox"/> <span style="color: red;">or Vision</span> <input type="checkbox"/> Coverage (other than listed above)?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please provide the following information.)		
Policyholder name: _____ Policyholder ID Number: _____ Group Number: _____		
Effective date of policy: _____		
Name and address of the insurance company: _____ _____ _____		

Please sign here: _____	<b>Date:</b> ____/____/____
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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 to the extent of any overpayment which is in excess of the amounts payable under the benefit plan administered by AmeriBen.

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. Please follow the instructions on the back of this form to file this claim with AmeriBen.

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## ***Procedure for Filing a Claim:***

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 sign.
  
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**
  - P.O. Box 7186**
  - Boise, Idaho 83707**