

MEDICAL CLAIM FORM

Trustmark Health Benefits

P.O. Box 2920

Clinton, IA 52733-2920

(913) 685-4740 (800) 990-9058 (913) 681-0886 Fax



Instructions:

- 1. Please complete all sections**
- 2. All itemized bills MUST be attached and include: Patient's name, Provider's name, diagnosis, dates of services and charge amount.**
- 3. If you or a dependent are covered by another Plan (including Medicare), please submit the bill to the Primary Plan first. Then send our office a copy of the Explanation of Benefits along with the bill.**

EMPLOYEE INFORMATION

Name (First, MI, Last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Member Number
Home Address		City	State	Zip
Employer:	Date of Hire	Occupation	Date Last Worked	

PATIENT INFORMATION

Patient Name (First, Middle, Last)		Relationship	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate
Is the Patient Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the Patient a Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How Many Hours?	Date Last Attended?	Name and Address of School
Nature of Illness		Name, Address and Phone No. of Doctor Seen For This Illness		

IF CLAIM IS BASED ON AN ACCIDENT, COMPLETE THE FOLLOWING

Date and Time of Accident	Was Accident Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place	How It Happened
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SPOUSE INFORMATION

Name (First, MI, Last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Soc. Sec. No.
Spouse's Employer Name		Address		Phone No.

OTHER INSURANCE INFORMATION

Do You or Your Dependents Have Other Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage? <input type="checkbox"/> Single <input type="checkbox"/> Family	Type of Plan? <input type="checkbox"/> Group Health Plan <input type="checkbox"/> Government Plan <input type="checkbox"/> Medicare <input type="checkbox"/> Other		
Name of Person Covered by Other Insurance	Group Number	Soc. Sec. No.	Benefits <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other	
Name and Address and Phone No. of Other Insurance Company				

AUTHORIZATION TO RELEASE INFORMATION --
 I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to Trustmark Health Benefits for any oral or dental observation, treatment, services, or benefits rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

 PATIENT'S SIGNATURE (PARENT IF MINOR) DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS --
 I hereby authorize payment of benefits to any providers of service rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

 PATIENT'S SIGNATURE (PARENT IF MINOR) DATE