HealthComp

MEDICAL CLAIM FORM

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

TO SUBMIT: Include the receipt and itemized superbill and upload via the chat messenger in your HealthComp portal OR mail them to the address listed on the back of your ID card under "Claims Submission."

Questions? *Visit: HealthComp.com or call*
Members 800-843-3831
Providers 877-625-0205

EMPLOYEE & EMPLOYER INFORMATION

Employer Name: Gunnison Watershed School District **Group #:** 113951 **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

Wait! Only sign this section IF you want the reimbursement to go to the provider! Otherwise, leave it blank.

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

Employee's Signature _____ **Date:**