Health Claim Form

Employees:

1. Please complete items 1 through 8 in full.
2. Please complete items 8 through 11 only if you have other medical coverage, including Medicare.
3. Please be sure to sign the authorization so we can release information on items 12 and 13 if necessary.
4. If you have submitted a request for benefits under another health plan (including Medicare), please attach a copy of the bills you sent to the other plan and the Explanation of Benefits form the plan sent to you.
5. Attach itemized bills or ask your health care provider to complete the applicable section. The bills must include:
   a. Patient's name
   b. Date(s) of service
   c. Condition being treated
   d. Relationship to employee
   e. Type of service(s) given

   If any of this information missing, simply write it on the bill and sign your name.
6. Keep copies of your bills for your records.
7. The mailing address for claims in on the back of your ID card. HealthSCOPE Benefits; P.O. Box 91603; Lubbock, TX 79490

Employee Information

1. Employee's SSN

Group Number

NVPEB

2. Patient's Name (Last, First, Middle)

3. Patient's Date of Birth **Gender**

☐ M ☐ F

4. Employee's Name (Last, First, Middle)

5. Patient's Address

City	
State/Zip	

6. Patient's Relationship to Employee

Self Spouse Child Other

7. Employee's Address

City	
State/Zip	

8. Patient Status

	Single	Married	Other
Employed?		☐ Yes	No ☐
Full Time Student?		☐ Yes	No ☐
Part Time Student?		☐ Yes	No ☐

9. Other Insured's Name (Last, First, Middle)

a. Other Insured's Policy or Group No.

b. Other Insured's Date of Birth

c. Employer's Name or School Name

d. Insurance Plan Name or Program Name

10. Is Patient's Condition Related to:

a. Employment? (Current or Previous)

☐ Yes No ☐

b. Auto Accident?

☐ Yes No ☐

c. Other Accident?

☐ Yes No ☐

d. Please provide accident details:

11. Employee's Policy/Group No.

a. Employee's Date of Birth

b. Claims Administrator

HealthSCOPE Benefits
P. O. Box 91603
Lubbock, TX 79490-1603
email: pebp@healthscopebenefits.com
www.healthscopebenefits.com

c. Is there another health benefit plan? (additional coverage)

☐ Yes No ■
(If Yes, return to and complete item 9 a-d)

12: Patient's or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed

Date

13: Authorized Person's Signature

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signed

Date

Physician and supplier form on reverse side...

Physician or Supplier Information

14. Date of Current Illness (First Symptoms) or Injury (Accident) or Pregnancy (LMP)

15. If Patient has had Same or Similar Illness Give First Date

16. Date Patient Unable to Work in Current Condition

From: To:

17. Name of Referring Physician or other Source

18. I.D. No. Of Referring Physician

20. Outside Lab? $ Charges

21. Diagnosis or Nature of Illness or Injury (Relate Items 1,2,3 or 4 to Item 24E by line)

22. Medicaid Resubmission

25.

27. Accept Assignment?

Yes No