MBA

THE OPEN SOLUTION™

Medical Claim Form

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO

MBA Benefit Administators
PO Box 57340, Murray, UT 84157-0340

PART 1 MUST BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	NAME OF EMPLOYER GROUP#	
HOME ADDRESS	EMPLOYEE BIRTH MO/DAY/YEAR DATE	IS PATIENT FULLTIME STUDENT Y N	NAME & ADDRESS OF SCHOOL
CITY & STATE / ZIP CODE	IS PATIENT COVERED BY MEDICARE Y N	PHONE NO.	
PATIENT (IF OTHER THAN EMPLOYEE) NAME	SEX / PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTH DATE MO/DAY/YR	IS PATIENT MARRIED Y N
NAME OF SPOUSE	NAME AND ADDRESS OF SPOUSE'S EMPLOYER		
NATURE OF SICKNESS, INJURY, DIAGNOSIS OR MEDICAL CALL	PHSYCIAN'S NAME		

ARE YOU THE PATIENT OR SPOUSE. COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? YES___ NO ___ IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF PLAN PROVIDING BENEFITS.
NAME AND ADDRESS POLICY NO.

IF PAYMENT IS TO BE MADE TO PROVIDER. SIGN BELOW

ASSIGNMENT:
PLEASE PAY BENEFITS UNDER THIS CLAIM DIRECTLY TO:
☐ HOSPITALS ☐ DOCTORS ☐ EMPLOYEE

A AUTHORIZATION TO PAY BENEFITS TO PROVIDERS:
I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Covered Person Date

B AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____
Patient or Parent of Minor Date

PROCEDURE FOR FILING A CLAIM

I. Complete "Employee" portion of the Claim Form.
   A. If the patient is your dependant be sure to complete all questions, including if married and a full-time student.
   B. It is important to know when, how and where your accident, illness or disability began, especially if it is job-related.
   C. "If payment is to be made to provider" you must always sign Section A.
   D. Patient (or parent where patient is minor) must always sign Section B. A claim form cannot be processed without this authorization and verification.

II. Check to ensure that all parts of the "Employee" portion of the claim form are complete.

III. If primary coverage is through another insurance submit your claim to them first. When you receive their payment statement or denial letter send that information with all bills and this form to MBA (for assistance in determination primary insurance, contact your claims processor).

IV. Attach all bills related to claim.
   A. Make sure all bills identify patient, and always include *Employee's* Social Security Number.
   B. All bills should show date of treatment, type of service, diagnosis and amount of charges.
   C. Prescription drug bills should be on regular receipts, showing name and address of pharmacy, name of patient, date of purchace, prescription number, name of medication and change.

V. Submit this form along with attached bills to the Benefits Department, at the above address.

P.O. Box 57340
Murray, UT 84157-0340
(801) 268-3334
(800) 877-3727
(801) 747-5205 (FAX)

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