Health Fair 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:
☐ 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 _____

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 _____

Please include a copy of your Health Fair receipt.

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