

Fax To: (520) 722-7127
 Mail form and attachments to:
 Mountain States Administrative Services
 7202 E Rosewood, Ste 200
 Tucson, AZ 85710
 (800) 866-4731 or (520) 722-0811



STATEMENT OF MEDICAL CLAIMS Request for Reimbursement

ANSWER ALL QUESTIONS

1. Employee's Name		Date of Birth	Sex	Card ID Number
2. Address		City	State	Zip Code Telephone
3. Employer's Name		Address		
4. Spouse's Name	Date of Birth	Is Spouse Employed: Yes <input type="checkbox"/> No <input type="checkbox"/>	Name and Address of Spouse Employer	
5. Is any member of the family covered by any other plans, which provide medical or dental benefits? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, name and address of other insurance: Effective date of other insurance: _____				
6. Patient Name	Relationship to Employee	Date of Birth	Sex	
7. Marital Status Married <input type="checkbox"/> Single <input type="checkbox"/>				
8. Is patient full time student: Yes <input type="checkbox"/> No <input type="checkbox"/>		Name and address of dependents employer or school		
9. Is claim result of injury: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of injury	How did injury happen?		
10. Is this a result of a work related injury Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes give details		
11. Name and address of attending physician (please print)				
12. Have you terminated your employment? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes give date of termination		

THE ABOVE INFORMATION REPRESENTS A TRUE AND COMPLETE STATEMENT TO THE BEST OF MY KNOWLEDGE

Signed (Employee) Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding the medical history, treatment, disability, or benefits payable for current Plan Year claims.

Signed (Patient, or parent if minor) Date

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician for benefits otherwise payable to me for services as described.

Signed (Employee) Date