

Please submit to:
Activa Benefit Services, LLC.
2905 Lucerne Dr., S.E., Suite 555
Grand Rapids, MI 49546
Claims-. 866-807-1097
Fax-. 616-787-4590

MEDICAL CLAIM

PATIENT INFORMATION			
Patient Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	Relation to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Other
If full time Student	School	City	
Is patient Employed? <input type="checkbox"/> Yes Employer Name _____ <input type="checkbox"/> No			
Employee Information			
Name	Empl. Soc. Sec No.	DOB	Status <input type="checkbox"/> Active <input type="checkbox"/> Retired
Mailing Address			
City	State	Zip Code	
CLAIM INFORMATION			
Claims for: <input type="checkbox"/> Accident <input type="checkbox"/> Illness	Is Condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will or has a third party liability claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe illness or accident		If accident, when and where did it occur	
Does patient have other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes what Type? <input type="checkbox"/> Medicare <input type="checkbox"/> HMO <input type="checkbox"/> Other _____ <input type="checkbox"/> No Fault Auto <input type="checkbox"/> Group <input type="checkbox"/> Private <input type="checkbox"/> Medicaid			
If yes above give name, address of other plan insurance carrier, HMO, Etc.			Policy or Plan No.
I certify that the information set forth in this claim form and any attachments is complete and accurate to the best of my information and belief. I authorize all appropriate persons or institutions to release to or obtain from the Plan administrator any information to process this claim. I agree to reimburse the Plan for any benefits paid on my behalf in the event that I or my dependent receives any monies which reimburses me for such expenses in whole or in part.			
Signature: X _____ Date: _____			
I authorize the benefit payment to be made directly to the Physician or Supplier.			
Signature X _____ Date: _____			
PHYSICIAN OR SUPPLIER INFORMATION			
Is condition related to:	Patient s Employment <input type="checkbox"/> Yes <input type="checkbox"/> No	An Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Date
Diagnosis or Nature of illness or injury			Referring Physician
1. 2. 3.			
Date of Service	Place of Service	Fully describe procedures, medical, or suppliers furnished for each date given identify with proced. code	Diagnosis Code Charges
Your patients Account No.	*Must be furnished under authority of law	Total Charge →	Amt. paid
Signature of Physician or supplier X _____ Date _____		Your social security No.	Balance Due
		Your Employer No	Physician's or supplier's name, address, Zip Code & telephone No.