

Mail completed form to:

The address on the back of your members ID card under "Claims Submission"

Questions?

Contact Personify Health via the website or phone number on the back of your member ID card.

Employee and employer information

Employer Name: _____ Group Number: _____ Member ID: _____
 Employee Name: _____ Home Phone: _____ Work Phone: _____
 Employee Address: _____ Employee Date of Birth: _____
 Employee Status: Active Retired COBRA Leave of Absence
 Marital Status: Single Married Divorced Separated Widowed

Patient and claim information

Patient's Name: _____ Date of Birth: _____ Gender: Male Female
 Patient's Address: _____
 Patient's Relationship to the insured: Self Child Spouse Stepchild Other

Accident/occupational claim information

Was condition related to patient's employment? Yes No Due to an accident? Yes No

Date of accident or beginning of illness: _____

Description of how accident or work related illness/injury occurred: _____

Are you or your dependents filling a claim or lawsuit against a third party including an insurance company in order to recover the costs incurred as a result of this accident or illness? Yes No

If yes, name and address of third party: _____

Family/other coverage information

Is your spouse employed? Yes No If no, has spouse been employed during last 12 months? Yes No

Name of spouse: _____ Spouse's date of birth: _____

Name and address of spouse's employer: _____

Is the patient covered under any other group insurance plan? Yes No If yes, effective date of coverage: _____

Name and address of health insurance company: _____

Policy number: _____ Member ID: _____ Phone: _____ Type: (medical/dental)

Is the patient covered under Medicare? Yes No If yes, effective date of coverage: _____

Certification

I certify that the information supplied is true and correct and that the bills attached were incurred by the patient listed above.

Employee's signature: _____ Date: _____

Authorization for release of records

I authorize any physician, hospital, any medical service organization, any insurance company or other institution or organization to release to each other any medical or other information acquired, concerning this or other disabilities. A photocopy of this authorization shall be as valid as the original.

Employee's signature: _____ Date: _____

Authorization to pay benefits to provider

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s).

Employee's signature: _____ Date: _____