



CLAIM FORM — GROUP MEDICAL

BEST Life and Health Insurance Company

Mail Completed Form To:

BEST Life and Health Insurance Company
P.O. Box 890 • Meridian, ID • 83680
(800) 433-0088 | Fax (208) 893-5040

PRE-CERTIFICATION REQUIRED

Pre-certification must be obtained for inpatient admissions, outpatient surgery procedures, MRIs, CAT Scans, PET scans, nuclear imaging and transplants. Failure to obtain pre certification may result in a reduction of benefits and/or additional financial responsibilities for the member. For pre-certification, call 1 (877) 773-7933.

TO BE COMPLETED BY EMPLOYEE • Answer all questions that apply • Sign where indicated by arrows(▶).

Employee Name, Sex (Male/Female), Date of Birth, Social Security Number, Street Address, City, State, Zip, Phone

Employed by (Company Name and Address), Policy No., Occupation/Job Title, Single/Divorced/Married/Widowed

Claim is Made for (Self/Spouse/Child), Name of Claimant, Claimant's Date of Birth, Spouse's Date of Birth, Male/Female

Was Disability Caused by Work? (Yes/No), Have you filed a claim with the Worker's Compensation carrier for this disability? (Yes/No), First Date Unable to Work (Date/Hour/a.m./p.m.), Date Returned to Work

Was Employee's spouse or any other family member employed in the last 12 months? If Yes - complete below. Table with columns: Name, Relationship, Name and Address of Employer

Does employee's spouse or other family member have insurance through employment? (Yes/No)
Does employee, spouse or child have any other group health insurance? (Yes/No)
Does employee, spouse or child have Blue Cross, Blue Shield, or Health Maintenance Organization (HMO) insurance? (Yes/No)
Does employee, spouse or child have Medicare or any other Federal or State Government Insurance? (Yes/No)
If this claim is for a dependent child, does the employee have financial responsibility for the child's expenses? (Yes/No)

Give other name and address of any other insurance company or organization providing benefits or services for employee, spouse or children. Table with columns: Insured, Name and Address of Insurance Company or Organization Providing Benefits or Services, Policy No. or Identification No.

Please list the names and addresses of any doctors who either examined, provided consultation, treated or prescribed medication for this patient in the last 12 months.

COMPLETE IF INJURY INVOLVED

Date of accident, Time (a.m./p.m.), Was claimant at work (Yes/No), For whom?

Place and details of accident (If more space needed attach additional sheet)

AUTHORIZATION FOR RELEASE OF INFORMATION - GROUP HEALTH BENEFITS

TO: Any physician, medical practitioner, hospital, clinic or other medically related facility or provider of medical or dental services, and any employer, group policyholder or contract holder or Insurer.

I authorize you to release to BEST Life or its representatives, any and all information you may have about the mental and physical history, condition, treatment, and insurance coverage of (Patient).

I understand that the information released under this authorization will be used for the purpose of evaluating and administering a claim for benefits, and I authorize BEST Life to redisclose the information for that purpose to my employer, union and the group policyholder or contract holder, or their representatives, to any reinsurer, and to any other Insurer or Self-Insurer to whom a claim for benefits may be submitted.

I also authorize BEST Life to redisclose the information to any person performing a business or legal function for its benefit, and to any person who has an authorization specifically permitting the redisclosure.

I agree that this authorization shall be valid for two years from the date shown below.

I know that I have a right to request to receive a copy of this authorization. A photocopy of this authorization shall be valid as the original.

Signature lines for Date, Insured's Signature, Spouse's Signature (only required if claim is on spouse)

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

Signed (Insured person)

CLAIM FORM MUST BE COMPLETED AND SUBMITTED WITH YOUR ITEMIZED BILLS WITHIN 90 DAYS FOLLOWING LOSS

HEALTH INSURANCE CLAIM—GROUP MEDICAL

Name of Patient:		Date of Birth:					
ATTENDING PHYSICIAN'S STATEMENT							
1. DIAGNOSTIC INFORMATION							
	ICDA-9 CM Code	Description					
Primary Diagnosis							
Secondary Diagnosis							
Other Diagnosis							
Are these services for second Surgical Opinion? Yes <input type="checkbox"/> No <input type="checkbox"/>							
2. REPORT OF SERVICES (If previous form submitted to BEST Life show only dates and services since last report.)							
Date of Services	Place of Services	Procedure Code (Must use CPT*)	Description of Services				
†O – Doctor's Office IH – Inpatient Hospital NH – Nursing Home H – Patient's Home OH – Outpatient Hospital OL – Other Locations ICDA – International Classification of Diseases *CPT – Current Procedural Terminology (Current Edition)			TOTAL CHARGES \$ _____ AMT. PAID BY PATIENT \$ _____ AMT. PAID BY OTHER INSURANCE \$ _____ BALANCE DUE \$ _____				
Could this have resulted from patient's employment? Yes <input type="checkbox"/> No <input type="checkbox"/>		Pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, approximate date pregnancy commenced: _____					
Date symptoms first appeared or accident happened: _____		Date patient first consulted you for this condition: _____					
Is patient still under your care for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>							
Has patient consulted you in the past for this or similar diagnosis(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, complete the following section:							
Date(s) of service	Diagnosis						
Is patient unable to work? (Totally disabled) Yes <input type="checkbox"/> No <input type="checkbox"/> Date(s) of total disability: From _____ Through _____							
If still disabled when will patient be able to return to work? _____		Does patient have any other health insurance or service plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, identify on next line.					
I DO NOT ACCEPT ASSIGNMENT OF BENEFITS <input type="checkbox"/>							
I hereby approve release of information pertaining to this patient to BEST Life and Health Insurance Company or its authorized representative on authorization of the insured.							
Physician's Name(Please Print)		Signature	Telephone				
Street Address		City or Town	State Zip Code				
Individual Practitioners - SS#:		<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>					
All others - Employer ID#:		<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 75%;"></td> </tr> </table>					
Tax identification number must be provided to avoid income tax withholding under federal law.							