Medical Benefits Request

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TO BE COMPLETED BY EMPLOYEE

1. EMPLOYER'S NAME			2. POLICY/GROUP NUMBER
3. EMPLOYEE'S ID NUMBER	4. EMPLOYEE'S NAME		5. EMPLOYEE'S BIRTHDATE
6. ☐ ACTIVE ☐ RETIRED - DATE:	7. EMPLOYEE'S ADDRESS (INCLUDE ZIP CODE) ☐ ADDRESS IS NEW		8. EMPLOYEE'S TELEPHONE NUMBER
9. PATIENT'S NAME	10. PATIENT'S ID NUMBER	11. PATIENT'S BIRTHDATE	12. PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
13. PATIENT'S ADDRESS (IF DIFFERENT FROM EMPLOYEE)			14. PATIENT'S GENDER ☐ MALE ☐ FEMALE
15. PATIENT'S MARITAL STATUS ☐ MARRIED ☐ SINGLE	16. IS PATIENT EMPLOYED? ☐ NO ☐ YES	17. NAME & ADDRESS OF EMPLOYER	
18. IS CLAIM RELATED TO AN ACCIDENT? ☐ NO ☐ YES IF YES, DATE_____ TIME_____ ☐ AM ☐ PM			19. IS CLAIM RELATED TO EMPLOYMENT? ☐ NO ☐ YES
20. 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 ☐ NO ☐ YES IF YES, EFFECTIVE DATE: _____		21. IF YES, GIVE NAME, ADDRESS AND POLICY NUMBER OF PLAN PROVIDING BENEFITS. NAME AND ADDRESS _____ POLICY NO. _____	
22. MEMBER'S ID NUMBER	23. MEMBER'S NAME		24. MEMBER'S BIRTHDATE (MM/DD/YYYY)

25. PATIENT OR PARENT MUST SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION: THE STATEMENTS ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY BELIEF. UPON PRESENTATION OF THE ORIGINAL OR A PHOTOCOPY OF THIS SIGNED AUTHORIZATION, I AUTHORIZE ANY MEDICAL PROFESSIONAL, HOSPITAL OR OTHER MEDICAL CARE INSTITUTION, INSURANCE SUPPORT ORGANIZATION, PHARMACY, GOVERNMENTAL AGENCY, INSURANCE COMPANY, GROUP POLICYHOLDER, EMPLOYER OR BENEFIT PLAN ADMINISTRATOR TO PROVIDE ACS BENEFIT SERVICES, LLC OR AN AGENT, ATTORNEY (CONSUMER REPORTING AGENCY) OR INDEPENDENT ADMINISTRATOR, ACTING ON ITS BEHALF, INFORMATION CONCERNING ADVICE, CARE OR TREATMENT PROVIDED THE PATIENT OR COVERED PERSON (OR DECEASED NAMED BELOW, OR INFORMATION RELATING TO THE DEATH OF SUCH PERSON), INCLUDING INFORMATION RELATING TO MENTAL ILLNESS, USE OF DRUGS OR USE OF ALCOHOL. I ALSO AUTHORIZE MY EMPLOYER, GROUP POLICYHOLDER OR BENEFIT PLAN ADMINISTRATOR TO PROVIDE ACS BENEFIT SERVICES, LLC WITH ANY FINANCIAL OR EMPLOYMENT-RELATED INFORMATION WHICH MAY BE PERTINENT TO THE CLAIM. I UNDERSTAND THAT SUCH INFORMATION WILL BE USED BY ACS BENEFIT SERVICES, LLC OR ITS AUTHORIZED REPRESENTATIVE FOR THE PURPOSE OF EVALUATING MY CLAIM FOR BENEFITS AND THAT I OR MY AUTHORIZED REPRESENTATIVE WILL RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. THIS AUTHORIZATION IS VALID FROM THE DATE SIGNED FOR THE DURATION OF COVERAGE UNDER THE PLAN.

DATE _____ 20_____ PLEASE SIGN _____ _____
EMPLOYEE PATIENT (OR IF A MINOR, PARENT)

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26. IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW **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 _____ DATE _____ 20_____

PROCEDURE FOR FILING A CLAIM

I. COMPLETE THE ABOVE EMPLOYEE STATEMENT

A. IT IS IMPORTANT TO KNOW WHEN, HOW AND WHERE YOUR ACCIDENT, ILLNESS OR DISABILITY BEGAN, ESPECIALLY IF IT IS JOB-RELATED.
B. PLEASE ANSWER COMPLETELY ALL QUESTIONS REGARDING OTHER COVERAGE.
C. IF APPLICABLE, SIGN ABOVE IF PAYMENT IS TO BE MADE TO A PROVIDER.
D. MAKE SURE THAT THE AUTHORIZATION SECTION IS SIGNED BY THE PATIENT, OR IN THE CASE OF A MINOR, BY THE PARENT.

II. IF YOU HAVE OTHER COVERAGE (INCLUDING MEDICARE OR CHAMPUS), MAKE SURE YOU ATTACH ALL PAYMENT WORK SHEETS, STATEMENTS, OR DECLINATION LETTERS.

III. PLEASE COMPLETE THIS FORM AND MAIL IT TO THE ADDRESS SHOWN BELOW. DO NOT ATTACH MEDICAL BILLS. MEDICAL BILLS SHOULD BE SENT TO THE ADDRESS ON YOUR IDENTIFICATION CARD. NOTE: PRESCRIPTION DRUG RECEIPTS SHOULD SHOW NAME AND ADDRESS OF PHARMACY, NAME OF PATIENT, DATE OF PURCHASE, PRESCRIPTION NUMBER, NAME OF MEDICATION AND CHARGES. **MAIL YOUR PRESCRIPTION DRUG RECEIPTS AND THIS FORM TO THE ADDRESS SHOWN BELOW.**

IV. **MEDICAL BILLS SHOULD BE MAILED TO THE ADDRESS SHOWN ON YOUR IDENTIFICATION CARD.

A. MAKE SURE ALL MEDICAL BILLS IDENTIFY THE PATIENT.
B. ALL BILLS SHOULD SHOW DATE OF TREATMENT, TYPE OF SERVICE AND AMOUNT OF CHARGES.
C. TO AVOID DELAYS IN PROCESSING YOUR MEDICAL BILLS MAKE SURE THEY ARE MAILED TO THE ADDRESS SHOWN ON YOUR IDENTIFICATION CARD.