Claim Form

AcuityGroup

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Fax: (601) 853-3064

Employer:_____

Group #:_____

Please use this form for medical, dental and Rx benefits.
It should be completed by the employee and returned to Acuity Group.

EMPLOYEE NAME	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER - -	MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W
ADDRESS (Street, City, State, Zip):			

DEPENDENT INFORMATION

LAST NAME FIRST NAME INITIAL	FULL-TIME STUDENT?		SEX	DATE OF BIRTH MO DAY YR	RELATIONSHIP
	☐ YES	☐ NO			
	☐ YES	☐ NO			
	☐ YES	☐ NO			
	☐ YES	☐ NO			
	☐ YES	☐ NO			

ARE THERE ANY OTHER HEALTH BENEFITS AVAILABLE (Including Medicare)? ☐ Yes ☐ No ☐ Group ☐ Individual ☐ Medicare	
NAME OF OTHER PLAN OR OTHER COVERAGE:	NAME OF PARTICIPANT
ADDRESS OF CLAIM DEPARTMENT:	SOCIAL SECURITY NUMBER:
	PLAN OR POLICY NUMBER:

Complete the following if this claim relates to an accident.

DATE ACCIDENT OCCURRED: / /	DATE FIRST TREATED / /	NAME OF FIRST PHYSICIAN CONSULTED:
HOW, WHERE AND WHAT TIME DID THE ACCIDENT OCCUR?		

PAYMENTS ARE MADE IN ACCORDANCE WITH THE PLAN OF BENEFITS ESTABLISHED BY THE EMPLOYER WITH CLAIM PROCESSING SERVICES BY ACUITY GROUP.

I HEREBY AUTHORIZE ANY DENTIST, PHYSICIAN, HOSPITAL, INSURANCE COMPANY, ORGANIZATION, OR EMPLOYER TO RELEASE ANY INFORMATION INCLUDING FULL COPIES OF THEIR RECORDS TO BENEFIT ADMINISTRATION SERVICES, LTD. FOR ANY MEDICAL TREATMENT, SERVICES OR BENEFITS RENDERED OR PAYABLE TO ME OR ON MY BEHALF. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I HEREBY CERTIFY THAT FOREGOING ANSWERS ARE TRUE AND CORRECT, TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE	DATE	*DEPENDENT'S SIGNATURE

*Dependent's Signature required if claim is on Spouse or Dependent Child over age 18.

IMPORTANT

Itemized bills for Hospital expense, Surgical or Medical treatments, Diagnostic Laboratory and X-ray examinations must be submitted with date and charge for each service. Prescription receipts should have name of Pharmacy - Date - Name of Drug - Prescribing Physician and Name of Patient.