Medical Claim Form

ADMINISTERED BY
Managed Care Administrators
P.O. Box 71838
Salt Lake City, UT 84171
Fax claims to: 801-274-8900

COMPLETE IN FULL & attach itemized statements for services, cash register receipts are not acceptable.
Form must be signed by the member or patient.

1. EMPLOYEE HEALTHCARE IDENTIFICATION NUMBER ________________ EMPLOYER: ________________ GROUP NO.__________
2. EMPLOYEE NAME: (PRINT) LAST________________ FIRST________________ M.I.________________
3. EMPLOYEE ADDRESS: STREET (P.O BOX)________________
   CITY________________ STATE______________ ZIP ________________
4. TELEPHONE NUMBER: (___________)________________
5. PATIENT IS: (CHECK ONE) ❑ EMPLOYEE ❑ FAMILY MEMBER
6. IF PATIENT IS FAMILY MEMBER, GIVE:
   PATIENT NAME: LAST________________ FIRST ________________ M.I.________________
   RELATIONSHIP TO EMPLOYEE:________________
   PATIENT BIRTHDATE: MONTH ____________ DAY ___________ YEAR ___________
7. DOES THE PATIENT HAVE OTHER HEALTH COVERAGE? ❑ NO ❑ YES, GIVE:
   NAME OF OTHER INSURANCE COMPANY:________________
   SOCIAL SECURITY NUMBER OF PATIENT:________________
   EFFECTIVE DATE OF COVERAGE: MONTH __________ DAY __________ YEAR__________ TYPE OF COVERAGE: ❑ MEDICAL ❑ DENTAL ❑ VISION
   IF PATIENT IS A CHILD, GIVE PARENTS BIRTHDATE(S): A) MOTHER: MONTH ___________ DAY __________ YEAR ___________
   B) FATHER: MONTH ___________ DAY __________ YEAR ___________
8. IS TREATMENT FOR INJURY? ❑ NO ❑ YES, If Yes DATE OF INJURY: MONTH ___________ DAY __________ YEAR _____________
   WHERE DID INJURY OCCUR? ❑ WORK ❑ HOME ❑ SCHOOL ❑ OTHER
   BRIEFLY DESCRIBE HOW INJURY OCCURRED:________________
   ____

   ARE YOU SEEKING REIMBURSEMENT FOR THE INJURY – ILLNESS THROUGH AN ATTORNEY? ❑ NO ❑YES
   NAME OF ATTORNEY________________
   ADDRESS________________ PHONE________________
9. PAYMENT FOR THE ATTACHED BILLS SHOULD BE MADE TO: (CHECK ONE) ❑ THE PROVIDER LISTED ON THE BILL(S) ❑ THE EMPLOYEE

PLEASE NOTE: When submitting this form to Managed Care Administrators, you authorize the service provider named in the attached bills to release medical and other information to Managed Care Administrators as needed to receive medical records and verify plan coverage.

10. EMPLOYEE SIGNATURE:________________ DATE: ________________