Managed Care Administrators
11550 South 700 East Suite 200
Draper, UT 84020

Medical Claim Reimbursement Form

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

Member's Identification Number: _____

Member's Name: (print)
Last _____First_____

Member's Address: Street (P.O Box)_____
City_____ State_____ Zip _____

Telephone number: (_____) _____

The patient is: (check one) □ Member □ Family Member

If the patient is a family member:
Patient's Name:
Last_____First_____

Relationship to Policy Holder: _____

Patient's birthdate: month _____ day _____ year _____

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 the patient is a child, give parents birthdate(s):
Mother: Month _____ Day _____ Year _____
Father: Month _____ Day _____ Year _____

Is treatment for the injury? □ No □ Yes, if yes date of injury:
Month _____ Day _____ Year _____

Where did the 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_____

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.

Member Signature: _____
Date: _____

Submit completed form & itemized statements to:
P.O. Box 958
Draper, UT 84020
Or
Fax Claims to 801-441-1234