MEDICAL EXPENSE
Claim Form and Instructions 6 W X G H Q W % O D Q N H W

1. PATIENT INFORMATION

Member ID	3 O H D V H H Q W H U W K H G L J L W V R I \ R X U , ' 1 X P E H U I U R P \ R X U F D U G	
Patient's Name *(Given Name, Family Name)*	Patient's date of birth *(MM/DD/YYYY)*	Patient's Gender
		Male Female
Name of Insured Member *(Given Name, Family Name)*	Insured's date of birth *(MM/DD/YYYY)*	Patient's Relationship to Insured
		Self Spouse Child
Name of Plan Program Sponsor	Insured's current mailing address	

Member Email	Member Phone Number

2. OTHER HEALTH INSURANCE

Is the patient covered under other health insurance?	YES NO	***If YES**, please complete this section*
Name and address of other insurance company		Name of the Policy Holder

Policy Holder's Date of Birth *(MM/DD/YYYY)*	Policy or identification number of other coverage	Effective Date *(MM/DD/YYYY)*	Termination Date *(MM/O*

FRAUD NOTICE

General Fraud Warning –
Any person who knowingly and with intent to defraud, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AUTHORIZATION FOR ASSIGNMENT

Authorization for Assignment –
All payments will be made to the Primary Insured if the doctor/hospital bills have been paid by you.
If you would like a third party to receive reimbursement for covered expenses under this policy, you must request an Authorization for Assignment from GeoBlue Member Services.