

Benefit Services, Inc.

P.O. Box 4138
Akron, OH 44321
(330) 666-0337 - FAX (330) 666-6685

Liberty Benton Local Schools

Statement of Claim

PART A EMPLOYEE MUST COMPLETE IN FULL

Patient's Name (First Name, Middle initial, Last Name)				Patient's Relationship to Insured				Patient's Sex		Patient's Date of Birth		
				Self	Spouse	Natural Child	Other	M	F	Mo.	Day	Year
Employee's Name and Home Phone						Social Security Number						
Address (Street, City, State, Zip Code)												
Is disability due to injury or accident?						If disability due to injury or accident, did it occur on the job?						
Date of Injury or Accident				Location				Describe Briefly				
Is patient covered by another medical insurance plan? Yes _____ No _____				Name, address and policy no. of insurance carrier:								
Spouse's Employer				Address (Street, City, State, Zip Code)				Spouse's Social Security Number				

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE IF DIRECT PAYMENT OF BENEFITS TO THE PHYSICIAN OR SURGEON IS DESIRED.
NOTE: ONCE BENEFITS ARE ASSIGNED, THE ASSIGNMENT CANNOT BE REVOKED.

(Read Before Signing)

Signed (Eligible Person) Date

AUTHORIZATION

- I hereby authorize any hospital, physician or other person who has attended or examined me to furnish Benefit Services all information with respect to this illness or accident, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records and permit the review, copying or photocopying of such records. A photostat of this authorization shall be considered as effective and valid as the original. If claim is on spouse, both husband and wife must sign.
- "Any person who knowingly and with intent to deceive files a statement of claim containing any materially false or misleading information is guilty of a crime." Please review this form thoroughly, Make certain all information is accurate and complete. Errors or omissions can result in payment delays or forfeiture of benefits. I certify that the information on this form is accurate and complete to the best of my knowledge.

Date Employee Sign Here

PART B TO BE COMPLETED BY PROVIDER OR SUPPLIER

Patient's Name			Relationship to Employee			Sex		Patient Birth Date		
			Self	Spouse	Child	M	F	Mo.	Day	Year
Patient's Address						City, State, Zip				

Diagnosis or nature of illness or injury. Relate diagnosis to procedure in Column D by reference to numbers 1, 2, 3, etc., or by DX Code.

Date of Service	Place of Service	Fully describe procedure, medical services or supplies furnished for each date given Proc. Code (Identify) (Explain unusual services or circumstances)	Diagnosis Code	Charges	Was condition related to Patient's Employment Yes _____ No _____ Accident Yes _____ No _____ Date Patient First Seen for This condition:	
Signature of physician or supplier				Total Charge	Amt. Paid	Balance
SIGNED _____ DATE _____				Physician's or supplier name, address, zip code and telephone no.		
Your patient's name and account No.				Your employer I.D. No.		
				I.D. No.		