personify HEALTH

Medical Claim Form

Receipt and itemized statement must be submitted with claim form for reimbursement.

Questions?

For questions and direction on how to submit your completed form,
please contact Personify Health via the website or phone number on the back of your ID card.

Employee and employer information

Employer Name: Group Number: Member ID:

Employee Name: Home Phone: Work Phone:

Employee Address: Employee Date of Birth:

Employee Status: Active Retired COBRA Leave of Absence

Marital Status: Single Married Divorced Separated Widowed

Patient and claim information

Patient's Name: Date of Birth: Gender: Male Female

Patient's Address:

Patient's Relationship to the insured: Self Child Spouse Stepchild Other

Accident/occupational claim information

Was condition related to patient's employment? Yes No Due to an accident? Yes No

Date of accident or beginning of illness:

Description of how accident or work related illness/injury occurred:

Are you or your dependents filling a claim or lawsuit against a third party including an insurance company in order to recover the costs incurred as a result of this accident or illness? Yes No

If yes, name and address of third party:

Family/other coverage information

Is your spouse employed? Yes No If no, has spouse been employed during last 12 months? Yes No

Name of spouse: Spouse's date of birth:

Name and address of spouse's employer:

Is the patient covered under any other group insurance plan? Yes No If yes, effective date of coverage:

Name and address of health insurance company:

Policy number: Member ID: Phone: Type: (medical/dental)

Is the patient covered under Medicare? Yes No If yes, effective date of coverage:

Certification

I certify that the information supplied is true and correct and that the bills attached were incurred by the patient listed above.

Employee's signature: Date:

Authorization for release of records

I authorize any physician, hospital, any medical service organization, any insurance company or other institution or organization to release to each other any medical or other information acquired, concerning this or other disabilities. A photocopy of this authorization shall be as valid as the original.

Employee's signature: Date:

Authorization to pay benefits to provider

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s).

Employee's signature: Date: