HealthComp

Send completed form by:
Fax: (985) 898-1666
Email: CustomerServe@HealthComp.com

General Information Verification
(Claim Form)

To maintain accurate and up-to-date information, please complete this form annually.

PLEASE COMPLETE THE FOLLOWING INFORMATION (please print):

Employer: _____ Group #: _____

Employee name: _____ SSN or ID #: _____

Phone #: _____ Address: _____

Are you or any members of your family covered under Medicare or any medical benefit plan other than the plan that is offered through your employer?

☐ No - If no, sign and date this form and return to HealthComp

☐ Yes - If yes, complete the information in the box below:

Dependent: _____ Date of birth: _____

Dependent: _____ Date of birth: _____

Dependent: _____ Date of birth: _____

Other insurance policy: _____

Address of other insurance company or plan: _____

Policyholder: _____ Date of birth: _____

Policyholder SSN or ID #: _____ Effective date of policy : _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for the services described.

AUTHORIZATION TO RELEASE INFORMATION AND AGREEMENT TO REIMBURSE: I authorize the release of any insurance information or information concerning health care advice, treatment or supplies provided to the patient (including those related to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. This authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I understand that I may revoke this authorization at any time by sending a written notice to HealthComp at the address given on this form. It will not have any effect on information already disclosed or collected. On behalf of myself, individually, and if the claimant is a minor, also as his/her legal guardian, I agree to reimburse the health plan from any funds received as a result of the third party's liability, including but not limited to those from any settlement, suit or judgment. In addition to this agreement to reimburse, I further acknowledge that the health plan shall have a right of subrogation against any third party responsible for benefits paid. A photocopy of this authorization and agreement to reimburse shall be as valid as the original. I know that I may request a copy of this authorization.

I represent that, to the best of my knowledge, the information provided on this form is complete and accurate. If other medical insurance coverage is obtained for any members of my family after this form is completed, I understand I am responsible for notifying HealthComp immediately.

_____ _____ _____

Signature (employee) Signature (patient, parent or legal gaurdian, if minor) Date:

**Signature and date required to submit form.*