

Complete and submit to  
Caprock HealthPlans

## Medical Claim Form

Mail Claim to:  
P.O. Box 15050  
Amarillo, TX 79105

**IMPORTANT:** Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on the bill.

<b>EMPLOYEE INFORMATION:</b>		<b>GROUP NAME, #:</b>			
Name (last, first, initial)		Sex	Employer Name		
Home Address		Identification Number	Birthdate	Group Number	
City	State	Zip Code	Work Telephone ( )	Home Telephone ( )	
<b>PATIENT INFORMATION:</b>					
The patient is: <input type="checkbox"/> <b>EMPLOYEE</b> <input type="checkbox"/> <b>SPOUSE</b> <input type="checkbox"/> <b>DEPENDENT CHILD</b>					
		(complete spouse information)		(complete spouse and child information)	
Spouse's Name (last, first, initial)		Sex	Child's Name (last, first, initial)		Sex
Spouse's Birthdate	Spouse's SSN	Child's Birthdate		Child's SSN	
Spouse's Employer					
Spouse's Employers' Address					
<b>DOES ANYONE HAVE ANY OTHER COVERAGE?</b>					
<input type="checkbox"/> <b>YES</b> (then complete) <input type="checkbox"/> <b>NO</b> (go to next section)		<b>NAME OF POLICYHOLDER:</b>			
Name of Other Health Insurance Carrier or Plan		Address	City	State	Zip Code
Other Insurance Carrier's or Plan's Telephone No.		Type of Coverage <input type="checkbox"/> <b>GROUP</b> <input type="checkbox"/> <b>INDIVIDUAL</b>	Group Number	Contract or Policy Number	
Spouse's Employer		If child is over age 19 and full-time student, complete: Name of School:			
Spouse's Employer's Address		School Address:			
<b>ABOUT THIS CLAIM</b>					
<input type="checkbox"/> <b>INJURY</b> <input type="checkbox"/> <b>ILLNESS</b>		Describe injury, when and how it happened or nature of illness:			
Date and time of accident:					
Was injury the result of auto accident? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>					
If auto insurance involved, please provide:		Policy No.	Name of Insurance Company	Address (City, State, ZIP Code)	
Did you or the patient receive, seek, or will be seeking monetary recovery for accident/injury? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>					
Work related injury? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>		<b>If injury is work related, please contact your employer for proper instructions regarding this claim.</b>			
<b>EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED - Authorization to release information</b>					
The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release of obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.					

Signature \_\_\_\_\_ Date \_\_\_\_\_

