TYPE OF CLAIM

- ☐ MEDICAL
- ☐ WELLNESS
- ☐ DENTAL

Please indicate by (X) type of claim (left). Claims not submitted within 90 days of date of incurrence are subject to review.

PROCEDURE FOR FILING A CLAIM

1. Complete PART 1 of the form labeled, "EMPLOYEE'S STATEMENT." Please answer ALL questions.
2. All questions concerning spouse's employer (No. 22.) and any other form of coverage (No. 23.) must be filled out completely. FAILURE TO DO SO WILL DELAY CONSIDERATION OF CLAIM.
3. The portion of the form labeled "Authorization to Pay Benefits to Providers" (No. 24.) is to be signed by you ONLY if benefits are to be paid to the Provider. If left blank, payment will be paid directly to you.
4. The portion of the form labeled "Authorization for Release of Information" (No. 25.) MUST be signed by patient (or parent-guardian if patient is a minor).
5. PART 2 of the form labeled "Provider's Statement" must be completed by the provider of services, unless provider's itemized statement is attached. NOTE: Provider's statement must include the "Diagnosis or Nature of Disease, or Injury" and Provider I.D. No. FAILURE TO DO SO WILL DELAY CONSIDERATION OF CLAIM.
6. Attach all bills securely to this form and mail directly to address below

PART 1A EMPLOYEE'S STATEMENT — MUST BE COMPLETED BY EMPLOYEE

1. EMPLOYEE
2. MEMBER NUMBER
3. OCCUPATION
4. HOME ADDRESS
5. CITY & STATE — ZIP
6. EMPLOYEE'S BIRTH DATE
7. PHONE NUMBER
8. PATIENT FULL TIME STUDENT? YES ☐ NO ☐
9. NAME & ADDRESS OF SCHOOL
10. PATIENT RELATIONSHIP TO EMPLOYEE
11. PATIENT BIRTH DATE
12. PATIENT (IF OTHER THAN EMPLOYEE) NAME
13. MALE ☐ FEMALE ☐
14. IS PATIENT MARRIED? YES ☐ NO ☐
15. PHYSICIAN'S NAME
16. DATE ACCIDENT OR SICKNESS BEGAN
17. IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?
18. DID ACCIDENT HAPPEN AT WORK? YES ☐ NO ☐
19. NATURE OF SICKNESS, INJURY, DIAGNOSIS, OR MEDICAL CALL
20. NAME OF SPOUSE
21. SPOUSE'S BIRTH DATE
22. NAME & ADDRESS OF SPOUSE'S EMPLOYER
23. ARE YOU, THE PATIENT OR SPOUSE COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? YES ☐ NO ☐ IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF PLAN PROVIDING BENEFITS.
    NAME AND ADDRESS — POLICY NO.

IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW

24. AUTHORIZATION TO PAY BENEFITS TO PROVIDERS:

I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X ______________________
Employee Signature — Date

SUBMIT CLAIMS OR QUESTIONS TO:

PBS
2255 N. 44th Street, Suite 250
Phoenix, AZ 85008

PATIENT OR PARENT MUST SIGN BELOW

25. AUTHORIZATION FOR RELEASE OF INFORMATION—GROUP HEALTH BENEFITS

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-Medical information of me or my minor children to disclose such information upon presentation of this authorization or photographic facsimile thereof. I UNDERSTAND the information obtained by use of the Authorization will be used by the Plan or its authorized claims paying administrator to determine eligibility for benefits or services under a policy. Any information obtained will not be released by the Plan to any person or organization, EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., employer, group policyholder, contract holder, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two and one half years from the date shown below.

X ______________________
Patient or Parent (If minor) — Date

PART 2 PROVIDER'S STATEMENT

MUST BE COMPLETED BY ALL MEDICAL & DENTAL PROVIDERS. FAILURE TO PROVIDE ALL INFORMATION WILL DELAY CONSIDERATION OF CLAIM

1. PATIENT'S NAME
2. AGE
3. SEX
4. DOES PATIENT HAVE OTHER COVERAGE? ☐ YES ☐ NO
IF YES, PLEASE COMPLETE THE FOLLOWING
CO. NAME
ADDRESS OR LOCATION
POLICY NO.

5. DIAGNOSIS OR NATURE OF DISEASE OR INJURY

6. OCCUPATIONAL INJURY? ☐ YES ☐ NO

7. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED
MO DA YR

8. DATE FIRST VISIT (CURRENT CONDITION)
MO DA YR

9. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
☐ YES ☐ NO

10. DATE OF TOTAL DISABILITY (UNABLE TO WORK OR PERFORM NORMAL ACTIVITIES)
MO DA YR

11. DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK
MO DA YR

12. DATE PATIENT RELEASED TO RETURN TO WORK
MO DA YR

13. HAS PATIENT HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO
IF YES, WHEN AND DESCRIBE:
MO DA YR

14. PREGNANCY?
☐ YES ☐ NO APPROXIMATE DATE PREGNANCY COMMENCED

15. DATE OF SERVICE MO	DA	YR	PLACE OF SERVICE CODE	PROCEDURE CODE *CRVS† ADA OR IDENTITY	LIST SEPARATELY SERVICES, MATERIALS AND FITTINGS (DENTAL—LIST TOOTH AND SURFACE)	CHARGES	CLAIMS OFFICE USE ONLY

NOTE: Provider I.D. No. or SS No. (No. 16) MUST be completed

16. NOTE: Provider I.D. No. or SS No.
17. TELEPHONE NO
18. DATE
TOTAL CHARGES

19. PROVIDER'S NAME AND DEGREE (PRINT)
20. PROVIDER'S SIGNATURE
AMOUNT PAID

21. ADDRESS
22. CITY
23. STATE
24. ZIP
BALANCE

25. WAS PATIENT REFERRED BY ANOTHER PHYSICIAN? ☐ YES ☐ NO
26. NAME OF REFERRING PHYSICIAN

DENTAL

HAVE SERVICES LISTED ABOVE BEEN PERFORMED?
☐ YES ☐ NO

IS TREATMENT FOR ORTHODONTIC PURPOSES?
☐ YES ☐ NO

IS TREATMENT DUE TO ACCIDENTAL INJURY?
☐ YES ☐ NO

IF PROSTHESIS, IS THIS INITIAL PLACEMENT?
☐ YES ☐ NO

IF "NO" DATE AND REASON FOR REPLACEMENT (NO. 5 ABOVE)

LIST SEPARATELY SERVICES, MATERIALS AND FITTINGS, INCLUDING CHARGES ABOVE

PLACE OF SERVICE CODE

11	PROVIDER'S OFFICE
OL	OTHER LOCATION
12	PATIENT'S HOME
32	NURSING HOME
21	INPATIENT HOSPITAL
22	OUTPATIENT HOSPITAL
24	OUTPATIENT SURGERY FACILITY

*CRVS—CALIFORNIA RELATIVE VALUE STUDIES †ADA—AMERICAN DENTAL ASSOCIATION