

ADMINISTERED BY:

PLEASE CHECK IF NEW ADDRESS

SUBSEQUENT MEDICAL CLAIM NOTICE



ENROLLEE INFORMATION:

Group # _____

ENROLLEE NAME		ENROLLEE SOCIAL SECURITY #		
ENROLLEE ADDRESS				
ENROLLEE HIRE DATE	EFFECTIVE DATE OF COVERAGE	TERMINATION DATE	COBRA EFFECTIVE DATE	DATE RETIRED

CLAIM INFORMATION:

PATIENT NAME		PATIENT'S DATE OF BIRTH		
CLAIM DUE TO Description		ILLNESS/ACCIDENT RESULT FROM EMPLOYMENT		
<input type="checkbox"/> ILLNESS/ <input type="checkbox"/> ACCIDENT		<input type="checkbox"/> YES <input type="checkbox"/> NO		

IF ACCIDENT - DATE AND TIME OF ACCIDENT	LOCATION OF ACCIDENT
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AUTHORIZATION TO PAY BENEFITS TO THE PROVIDER. I hereby authorize payment directly to the Provider of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services as described below or on the attached bills but not to exceed the reasonable and customary charge for those services.	SIGNED (ENROLLEE)	DATE
AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.	SIGNED (ENROLLEE)	DATE

Medical Claims:
 HealthSmart
 P.O. Box 53010
 Lubbock, TX 79453

Dental Claims:
 AAG
 P.O. Box 93670
 Lubbock, TX 79493-3670