Claim Reimbursement Form

1. Obtain an itemized bill from your medical provider.
2. Complete this form in full and sign below.
3. Please provide proof of payment.
4. Mail to:

FRINGE BENEFIT COORDINATORS, INC
2005 COBBS FORD RD., SUITE 401-A
PRATTVILLE, AL 36066

Fringe Benefit Coordinators, Inc.
2005 Cobbs Ford Rd., Suite 401-A
Prattville, AL 36066
(888) 500-1962 Fax (334) 212-8456

PART 1 – EMPLOYEE/SUBSCRIBER SECTION - PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME		SOCIAL SECURITY #	NAME OF EMPLOYER
EMPLOYEE MAILING ADDRESS	EMPLOYEE BIRTHDATE	OCCUPATION	GROUP NUMBER
CITY STATE ZIP	PHONE #	EMAIL ADDRESS	CLAIMS SUBMISSION DATE

PART 2 – PATIENT INFORMATION

PATIENT NAME			PATIENT BIRTHDATE	RELATIONSHIP TO MEMBER: ☐ SELF ☐ SPOUSE ☐ CHILD
FIRST VISIT DATE	PLACE OF TREATMENT	RECEIPTS / ITEMIZED STATEMENT ENCLOSED	HOW MANY?	PATIENT'S MEDICAL ID NUMBER
NAME AND ADDRESS OF PHYSICIAN (I.E DOCTOR OFFICE, CLINIC, HOSPITAL)			REASON FOR DOCTOR VISIT	

PATIENT OR PARENT MUST SIGN AND DATE BELOW

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.

PATIENT/PARENT IF MINOR _____ DATE

IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):
I hereby authorize payment of benefits directly to any providers of service, 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.

EMPLOYEE _____ DATE

PART 3 – CLAIM SUBMISSION DETAIL- *For any information below, please consult your provider*

DATE FIRST CONSULTED FOR THIS CONDITION?		PATIENT ACCOUNT #	
NAME OF REFERRING PHYSICIAN (E.G. PUBLIC HEALTH AGENCY)		TAX I.D. # or SSN	IF AN EMERGENCY, CHECK HERE ☐
PHYSICIAN FACILITY ADDRESS		PHONE #	DATE OF SERVICE
CITY	STATE ZIP	PLACE OF SERVICE (IF DIFFERENT FROM PROVIDER'S OFFICE LISTED)	
PROVIDER NPI	OFFICE/FACILITY TIN	DIAGNOSIS CODE	SERVICE CODE (FROM PROVIDER OR PROVIDER'S INVOICE)
CHECK PAYABLE TO: ☐ MEMBER ☐ PROVIDER		FOR SERVICES RELATED TO HOSPITALIZATION, PLEASE PROVIDE DATES: ADMITTED: _____ DISCHARGED: _____	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (PLEASE INDICATE PRIMARY AND SECONDARY)			
IS TREATMENT THE RESULT OF ILLNESS OR ACCIDENTAL INJURY? ☐ YES ☐ NO WORK RELATED? ☐ YES ☐ NO			

PROCEDURES, MEDICAL SERVICES, SUPPLIES FURNISHED:

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SERVICE	PROCEDURE CODE	TYPE OF SERVICE	CHARGES	DAYS OR UNITS	DIAGNOSIS CODE

PHYSICIAN'S SIGNATURE DATE

PHYSICIAN'S STAMP