Medical Claim Form

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO:

Rocky Mountain Administrators
P.O. Box 788
Worland, WY 82401
(307) 347-2606 • (800)383-8808

MUST BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME	PARTICIPANT ID NUMBER	NAME OF EMPLOYER	
HOME ADDRESS	EMPLOYEE BIRTH DATE	OCCUPATION	GROUP NUMBER
CITY STATE ZIP CODE		PHONE NUMBER	

PATIENT (IF OTHER THAN EMPLOYEE)	SEX	PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTH DATE	IS PATIENT MARRIED?
	F			YES ☐ NO ☐

DATE ACCIDENT OR SICKNESS BEGAN	IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?	DID ACCIDENT HAPPEN AT WORK?
		YES ☐ NO ☐

NATURE OF INJURY DIAGNOSIS OR MEDICAL:	PHYSICIAN'S NAME

NAME OF SPOUSE	NAME AND ADDRESS OF SPOUSE'S EMPLOYER

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENACE 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.

A. IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW

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_____
Covered Person Date

B. PATIENT OR PARENT MUST SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any insurance company, prepayment organization, 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 or services. I hereby certify the information provided is correct and true to the best of my knowledge.

X_____
Patient or Parent (if minor) Date

PROCEDURE FOR FILING A MEDICAL CLAIM

1. Complete "Employee" portion of the Medical Claim Form.
   A. If the patient is your dependent be sure to complete all questions.
   B. It is important to know when, how and where your accident, illness or disability began, especially if it is job-related.
   C. If payment is to be made to provider, you must always sign Section A.
   D. Patient (or parent where patient is minor) must always sign Section B. A claim form cannot be processed without this authorization and verification.
2. Check to ensure that all parts of the "Employee" portion of the claim form are complete.
3. If primary coverage is through another insurance, submit your claim to them first. When you receive their payment statement or denial letter EOB (Explanation of Benefits) send that information with all bills and this form to Rocky Mountain Administrators.
4. Attach all medical bills related to claim.
   A. Make sure all bills identify patient, and always include Employee's Unique Identification Number.
   B. All bills should show date of treatment, type of service, diagnosis and amount of charges.
   C. Prescription drug bills should be on regular receipts, showing name and address or pharmacy, name of patient, date of purchase, prescription number, name of medication, NDC number, and charge.
5. Submit this form along with attached medical bills to the Benefits Department, at the above address.

NAMES YOU KNOW, EXPERIENCE YOU CAN TRUST