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Summit Healthcare

Medical & Vision Claim Form

Patient Information		
1. Patient's Name (First, Middle Initial, Last)	2. Patient's Date of Birth	3. Patient's Address (Street, City, State, Zip Code)
4. Patient's Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Was condition related to: a. Patient's employment <input type="checkbox"/> Yes <input type="checkbox"/> No b. An auto accident <input type="checkbox"/> Yes <input type="checkbox"/> No c. Other type of accident <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
7. Nature of Injury (Please provide details of the accident or injury (how, when, where). Use the back of this page if additional room is needed.)		

Subscriber or Policyholder Information		
8. Subscriber's Name (First, Middle Initial, Last)	9. Subscriber's Social Security Number or ID number	10. Subscriber's Address (Street, City, State, Zip Code)
11. Subscriber's Group Number <b>0108001</b>	12. Subscriber's Group Name <b>Summit Healthcare</b>	
13. Is there other Medical <input type="checkbox"/> Dental <input type="checkbox"/> or Vision <input type="checkbox"/> Coverage (other than listed above)? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please provide the following information.)		
Policyholder name: _____ Policyholder social security number: _____		
Group number: _____ Effective date of policy: _____		
Name and address of the insurance company: _____ _____ _____		

14. Patient's or authorized person's signature I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing any time, provided that I do so in writing, except to the extent that the action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire one (1) year from the date of signing.  Please sign here:	Date
15. Subscriber's or Authorized person's signature I authorize payment of medical benefits to the physician or supplier of services. I understand that I may revoke this authorization in writing any time, provided that I do so in writing, except to the extent that the action has been taken in reliance upon this authorization.  Please sign here:	Date

By signing above, I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse AmeriBen Solutions (ABS) to the extent of any overpayment which is in excess of the amounts payable under the benefit plan administered by ABS.

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.