VISION

PLEASE RETURN THIS FORM TO ▶

Professional Risk Management, Inc.
P.O. Box 1049
Youngstown, Ohio 44501
(330)726-5666
Watts #: 1 (800) 331-7620

BENEFIT CLAIM FORM

EMPLOYEE'S STATEMENT: SECTIONS 1 THRU 24 TO BE COMPLETED BY THE **EMPLOYEE**

1. NAME OF EMPLOYER	2. LOCATION	3. EMPLOYEE'S SOC. SEC. NO.
4. NAME OF EMPLOYEE:	5. DATE OF BIRTH MO. / DAY / YEAR	6. ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOW
7. ADDRESS OF EMPLOYEE: STREET / CITY STATE ZIP	8. SEX ☐ MALE ☐ FEMALE 10. TELEPHONE NO.	9. CHECK BOX IF ADDRESS HAS CHANGED SINCE LAST REPORTED ☐

THIS CLAIM IS FOR:

11. PATIENT NAME	12. RELATIONSHIP TO EMPLOYEE: Self / Spouse / Child / Other	13. SEX: M / F	14. PATIENT BIRTHDATE: MO. / DAY / YEAR	15. FULL TIME STUDENT: ☐ YES ☐ NO; SCHOOL; CITY	15A. QUALIFIES AS TAX EXEMPTION ☐ YES ☐ NO 16. EMPLOYED ☐ YES ☐ NO 17. FULL TIME ☐ PART TIME ☐

18. IS EMPLOYEE'S HUSBAND/WIFE: ☐ EMPLOYED ☐ RETIRED ☐ NOT EMPLOYED ☐ DISABLED

IF EMPLOYED (RETIRED) NAME OF EMPLOYER: _____

ADDRESS: _____
STREET

_____
CITY STATE ZIP

19. IS THERE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO EFFECTIVE / TERMINATION DATE: _____

IF YES, COMPLETE: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ SINGLE COVERAGE ☐ FAMILY COVERAGE

NAME: _____ INSURANCE CO. OR HMO: _____

SOCIAL SECURITY: _____ ADDRESS: _____

DATE OF BIRTH: _____ _____ Phone: _____

20. IS THE PATIENT ELIGIBLE FOR MEDICARE (PART A AND/OR B)? ☐ YES ☐ NO

DATE ELIGIBLE _____ IS PATIENT ENROLLED FOR MEDICARE PART B ☐ YES ☐ NO

21. ☐ **AN INJURY**

Date _____ Where did it occur? _____

How did it happen? _____

Was the accident connected with the patient's employment? ☐ YES ☐ NO

22. ☐ **A SICKNESS**

Date symptoms began? _____ When did patient first consult a doctor? _____

Name of Doctor _____ Address _____

Was this condition connected with the patient's employment? ☐ YES ☐ NO

23. AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the provider of services, for services as described but not to exceed the reasonable and customary charge for those services. However, I realize that this assignment may be superseded by a contracting/non-contracting provider arrangement if such exists.

SIGNED (EMPLOYEE) ▶ **DATE**

24. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider of services to release any information acquired in the course of my examination or treatment to my claims administrator and to claim review organizations/individuals contracted by my claims administrator.

SIGNED (PATIENT, OR PARENT, IF MINOR) ▶ **DATE**

SEE CLAIM FILING INSTRUCTIONS ON BACK OF THE FORM.

* Important Notice - "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."