Medical Claim Form

Attach Itemized Bills and
Return This Form To:

Southwest Health Benefits Fund
8441 Gulf Freeway, Suite 304
Houston, TX 77017
Phone: 866-236-3148
Fax: 866-316-4794

To Be Completed By Insured/Employee

Last Name First Middle

Home Address

City-State-Zip Code

Phone Number

Date of Birth Sex Social Security #

Name of Contractor

Yes No

☐ ☐ IS DISABILITY DUE TO CLAIMANT'S OCCUPATION?

☐ ☐ ARE YOU (OR DEPENDENT-IF A DEPENDENT CLAIM) INSURED UNDER ANY OTHER GROUP HOSPITAL AND SURGICAL INSURANCE OR PLAN?

Other policy number Name of other insurance co. or plan

The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A Photostat of this authorization shall be as valid as the original.

_____

EMPLOYEE'S SIGNATURE **DATE**

Is Claim for A Dependent?

Name Relationship

Date of Birth

If Working, Employers Name & Address

Was Accident Involved?

Date of Accident Hour (AM-PM)

Where did Accident Occur?

Describe Accident Fully:

AUTHORIZATION

Important: You must indicate to whom benefits are to be paid.
I authorize payment to:

☐ Myself ☐ Dr. _____

I understand I am financially responsible for any expense not covered by this insurance.

Date _____ Member's Signature _____

For Eligibility and Benefits call: (866) 236-3148