DUNN & Associates
BENEFIT ▪ ADMINISTRATORS ▪ INC.

HEALTH CLAIM FORM

EMPLOYEE INFORMATION

Employee's Name:	Date of Birth: / /	Social Security Number: – –
Address (Home): *Check if new address* ☐ City State ZIP	Sex: ☐ Male ☐ Female	Marital Status ☐ Single ☐ Other: ☐ Married

PATIENT INFORMATION

Patient's Name:	Date of Birth: / /	Relationship to Employee: ☐ Self ☐ Child ☐ Spouse ☐ Other:
Address: City State ZIP	Sex: ☐ Male ☐ Female	Marital Status ☐ Single ☐ Other: ☐ Married

Full-time Student? ☐ Yes ☐ No If yes: _____ (Name and Address of School)

Employed Full-time? ☐ Yes ☐ No If yes: _____ (Name and Address of Employer)

OTHER COVERAGE INFORMATION

Does the patient have other coverage? ☐ Yes ☐ No **If yes, continue below:**

Type of Insurance/Coverage *(check all applicable choices)*:

☐ Medicare ☐ Group ☐ COBRA ☐ Other:	☐ Single ☐ Family ☐ Other:	☐ Medical ☐ Dental ☐ Vision ☐ Other:

Company Name:	Address: City State ZIP
Policy or Group Number:	Coverage Dates: _____ (Start) to _____ (End)

ACCIDENT INFORMATION

Were services received due to an accident? ☐ Yes ☐ No **If yes, continue below:**

Date of Accident:	Location of Accident: ☐ Work (If work, need to file claim w/ employer first) ☐ Home ☐ Vehicle ☐ Other:

Is payment expected from other source(s)? ☐ Yes ☐ No

If yes: Company Name: _____ Address: _____ City State ZIP

Describe Accident, including name(s) of any other people involved on reverse side and/or separate sheet of paper.

ASSIGNMENT/AUTHORIZATION

Assignment: ☐ Make payment to PROVIDER ☐ Make payment to MYSELF *(check one)*

I authorize Dunn and Associates to release any medical information related to this claim to applicable health care providers and/or other plan administrators when necessary to process this claim. It is understood that this authorization will remain in effect for the greater of the duration of coverage period or until the claim has been processed. It is also understood that a copy of this authorization is as valid as the original and a copy will be supplied to the patient upon request.

Signing below confirms that I have read and agree with the above authorization, agree with the payment method mentioned above, and attest to the accuracy of all other information provided by myself on this claim form.

_____ Patient's (or Guardian's) Signature
_____ Relationship to Patient
_____ Date

MAIL COMPLETED CLAIM FORM AND ORIGINAL BILLS TO:
Dunn and Associates Benefit Administrators, Inc.; PO Box 2369; Columbus, IN 47202-2369