HEALTH/DENTAL/VISION CLAIM FORM *(mail form and original bills to Dunn & Associates)*

Employee Information

Employee Name: _____

Employee Address/City/State/Zip: _____

Employee Identification # (or SSN): _____ *Located on ID Card*

Employee Date of Birth: _____ Employee Gender: ☐ Female ☐ Male

Employee Marital Status: ☐Single ☐Married ☐Divorced ☐ Other _____

Patient Information

Patient Name: _____

Patient Address/City/State/Zip: _____

Patient Identification # (or SSN): _____ *Located on ID Card*

Patient Date of Birth: _____ Patient Gender: ☐ Female ☐ Male

Patient relationship to Employee: ☐Self ☐Spouse ☐Child ☐ Other

Patient Marital Status: ☐Single ☐Married ☐Divorced ☐ Other

Patient Status: ☐Full-time Student ☐Employed
Please provide name/address of School/Employer.

Name: _____

Address: _____

Other Coverage Information

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

Insurance Coverage Company Name: _____ ID/Policy# _____

Insurance Coverage Company Address/City/State/Zip: _____

Type of Coverage (check all that apply): ☐ Group Coverage ☐ COBRA ☐ Medicare/Medicaid ☐ Other

Tier of Coverage (check all that apply): ☐ Single ☐ Family

Coverages (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Other

Coverage Dates: *Start Date* _____ *End Date (if applicable)* _____

Accident Information - If claim is due to an accident, please fill out an Accident Questionnaire

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

Location of Accident: ☐ Work ☐ Home ☐ Vehicle ☐ Other *If work, a claim needs filed with employer first.*

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

Company Name: _____

Company Address: _____

City/ST/Zip: _____

Assignment/Authorization

Assignment: ☐ Make a payment to PROVIDER ☐ Make payment to SELF (please 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 (or Guardian's) Signature _____ Relationship to Patient _____ Date: _____

Return completed form to: Dunn & Associates

Mail: PO Box 2369 Columbus, IN 47202-2369 - Fax: (812) 378-9967 - Email: info@dunnbenefit.com

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