



# MEDICAL CLAIM FORM

P5 Health Plan Solutions, PO Box 9554, Salt Lake City, UT 84109-0554  
 Customer Service (toll-free): 800-922-1855 (Fax): 801-412-8550

For Employers Resource  
 Deluxe, Preferred and  
 Consumer Direct \$20,000  
 and \$50,000 Medical Plans

## PATIENT INFORMATION (must attach billing receipt(s) with procedure/CPT codes)

1. EMPLOYEE'S Social Security Number		GROUP NUMBER <b>5837</b>		GROUP NAME <b>Employers Resource Benefit Trust</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTHDATE (mm/dd/yr) / / <input type="checkbox"/> M <input type="checkbox"/> F		4. EMPLOYEE'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS		6. PATIENT'S RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		7. EMPLOYEE'S ADDRESS	
CITY	STATE	8. PATIENT STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student		CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code)			ZIP CODE	TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. EMPLOYEE'S POLICY GROUP	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)		a. EMPLOYEE'S DATE OF BIRTH (mm/dd/yr) / / SEX <input type="checkbox"/> M <input type="checkbox"/> F	
b. OTHER INSURED'S POLICY OR GROUP NUMBER		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. CLAIMS ADMINISTRATOR / MAIL OR FAX CLAIM TO: <b>P5 Health Plan Solutions PO Box 9554 Salt Lake City, UT 84109-0554 Fax: 801-412-8550</b>	
c. EMPLOYER'S NAME OR SCHOOL NAME		d. PLEASE PROVIDE ACCIDENT DETAILS: _____ _____		c. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d</i>	
d. INSURANCE PLAN NAME OR PROGRAM NAME				13. AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					
<input type="checkbox"/> 14. If I check this box, and should this claim include eligible out-of-pocket expenses on my part, I approve P5 Health Plan Solutions to reimburse me such amount out of my eligible Employers Resource Health FSA first, then my eligible Employers Resource HRA (if applicable). If I do not check this box, I understand I would separately have to submit any eligible FSA or HRA expense(s) with a separate Reimbursement Form and documentation or use my HRA/FSA debit card. I also understand I cannot use a debit card <u>and</u> be reimbursed for such an eligible expense.					

## PHYSICIAN OR SUPPLIER INFORMATION (if no receipt is attached)

15. DATE OF CURRENT ILLNESS (First symptom) or INJURY or PREGNANCY (LMP) (mm/dd/yr) / /		16. IF PATIENT HAS HAD SAME/SIMILAR ILLNESS, GIVE FIRST DATE (mm/dd/yr) / /		17. DATES PATIENT IS UNABLE TO WORK IN CURRENT OCCUPATION FROM (mm/dd/yr) / / TO (mm/dd/yr) / /						
18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		19. I.D. NUMBER OF REFERRING PHYSICIAN		20. HOSPITAL DATES RELATED TO CURRENT SERVICES FROM (mm/dd/yr) / / TO (mm/dd/yr) / /						
				21. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____						
22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY ITEMS 1, 2, 3 OR 4 TO ITEM 24 E BY LINE 1. _____ 3. _____ 2. _____ 4. _____				23. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____						
24. PRIOR AUTHORIZATION NUMBER _____										
25. A	B	C	D	E	F	G	H	I	J	
DATE(S) OF SERVICE From (mm/dd/yr) to (mm/dd/yr)	Place of Service	Type of Service	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstance) CPT HCPCS / MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSOT Family plan	EMG	COB	
26. FEDERAL TAX I.D. NUMBER SSN EIN		27. PATIENT'S ACCOUNT NO.		28. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		29. TOTAL CHARGES		30. AMOUNT PAID		31. BALANCE DUE
32. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____		33. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) _____ _____			34. PHYSICIAN'S/SUPPLIER BILLING ADDRESS  PIN# _____ GRP# _____					