

INSTRUCTIONS: Please type or print the required information. If the patient receiving the service is not you, please indicate the relationship (spouse or dependent child). Sign and return a copy of this form by mail to **Integra BMS, P.O. Box 1178, Matthews, NC 28106** or fax it to **704.845.5629**. You may contact Integra BMS at **1.800.228.1803** or info@integrahealth.com with any questions.

Claim Type (circle one):	<i>PPO Medical claim</i>	<i>Non-PPO Medical claim</i>	<i>Dental claim only</i>	<i>Prescription drug claim only</i>
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SECTION (I) - PERSONAL INFORMATION

Employee Last Name	Employee First Name		Employee Middle Initial
Member ID	Home Phone Number	Work Phone Number	E-mail address
Patient Name (write "self" if you)	Patient relationship to you	Patient Date of Birth	Employer Group Number and Name <i>(group number is assigned by Integra BMS)</i>

SECTION (II) - ACCIDENT INFORMATION

If this claim is a result of an accident you must complete the Accident Information Letter. This letter is located on the website under Forms & Downloads under the Letters. You have the option to complete it online or to download and print the letter.

SECTION (III) - OTHER INSURANCE INFORMATION - Complete this section completely.

<i>Please read the question below and check yes or no in the box to the right</i>	YES	NO
Is the patient covered by any other group medical plan besides this Plan?		
Is the patient covered by any other private medical, dental, or accident insurance plan?		
Is the patient covered by any government sponsored medical plan such as Medicare or Medicaid?		

If you answered yes, please furnish details about any other insurance in the box below.

Name of other insurance carrier:	Policy Number of other carrier:
Effective Date of other insurance:	Other carrier's phone #:
List all family members covered by this plan:	

SECTION (IV) - EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that all information on this claim is accurate and that no information has been omitted.

Employee Signature	Date
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