ENTRUST
HEALTH. PLANNED.

Fax to: (281)-368-7827

STATEMENT OF CLAIM FORM

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.

I.D. Number - Copy this from you Identification Card: PLEASE PRINT

Plan Name:	Plan Number:

Patient Information - A separate claim form must be completed for each family member.

Patient's Full Legal Name: (Last, First, Middle Initial)	Gender: ☐ Male ☐ Female	Date of Birth: Month / Day / Year - -

Patient is: ☑ Member ☐ Spouse ☐ Child ☐ Step-Child ☐ Other, please explain relationship:

Payee - Indicate how payment is to be made

☐ Make payment to **PROVIDER** (hospital, doctor, etc.) ☐ Make payment to **MEMBER**, provider has been paid

Employee Information

Employee Name:	Social Security Number: - -	Date of Birth: Month / Day / Year - -

Current Address: City: State: Zip:

Home Phone: Cell Phone:

Date you last worked for this Employer? ☐ Active ☐ Retired

Claim Information

Is claim for an accident injury? ☐ Yes ☐ No	Was it work related? ☐ Yes ☐ No	Date of accident?	Where did it happen? ☐ Work ☐ Home ☐ Other

Briefly describe injury: *Complete if non-accidental injury or illness*

Number of bills submitted:	Briefly describe the condition(s) for which the patient received these services: (You can usually copy the diagnosis or description of services from the provider bill)
1	reimbursement for glasses

Spouse Information

Spouse's Name:	Social Security Number: - -	Date of Birth: Month / Day / Year - -

Is your spouse employed? ☐ Yes, please provide information below. ☐ No

Employer Name:

Does your spouse have other insurance? ☐ Yes, please provide information below. ☐ No

Insurance Carrier Name:	Phone Number:

Policy Number:	Effective Date:

Other Insurance Information (for family members other than your spouse)

Are there any OTHER medical benefits available to you or your dependents from OTHER group insurance? (Example: Blue Cross or Blue Shield policies. OTHER employer: Labor or Professional Organization, School, Sport or Travel groups, TRICARE, Medicare, Medicaid)

☐ Yes, please provide information below ☐ No

Is this an Individual Policy: ☐ Yes ☐ No Is this a Group Policy ☐ Yes ☐ No

Policy Holder Name:	Policy Holder is: ☐ Member ☐ Dependent

Insurance Carrier Name:	Phone Number:

Policy Number:	Effective Date:

I certify that the above information is correct and that the bills attached were incurred by the patient listed above. I authorize any medical professional, hospital, medical or medically related facility, pharmacy, government agency, insurance company, or other person or firm to provide Entrust, Inc. information including copies of records concerning advice, care or treatment provided the patient above including, without limitation, information relating to mental illness or use of drugs or alcohol, upon presentation of the original photocopy of this signed authorization. I understand that such information will be used by Entrust, Inc. for the purpose of evaluating a claim for benefits for services provided to the patient named above. I understand that I or any authorized representative will receive a copy of this authorization upon request. The authorization is valid from the date signed for the duration of the claim.

Signature of Employee: Date:

Signature of Patient: Date:

FAX OR SEND COPY TO:

Entrust, Inc., 22322 Grand Corner Dr., Suite 200, Katy, Texas 77494 Phone: (281) 368-7878 Fax: (281) 368-7827

05/01/2015