CLAIM FORM

1. COMPLETE THIS FORM IN FULL AND SIGN BELOW.
2. ATTACH ALL BILLS.
3. MAIL TO:

Fringe Benefit Coordinators
P O BOX 771
Kathleen, FL 33849

FRINGE BENEFIT COORDINATORS

P O Box Kathleen, FL 33849
(352) 377-1239 Fax (352) 372-9805
WWW.FBC-INC.COM

PART 1 EMPLOYEE STATEMENT — PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME	SOCIAL SECURITY #	NAME OF DISTRICT GILCHRIST	
EMPLOYEE MAILING ADDRESS	EMPLOYEE BIRTH DATE	OCCUPATION	GROUP NUMBER _____
CITY STATE ZIP	PHONE NO.	EMAIL ADDRESS (OPT)	NAME OF SCHOOL

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? ☐ YES ☐ NO
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? ☐ YES ☐ NO
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? ☐ YES ☐ NO

IS THE PATIENT A FULL TIME STUDENT? YES ☐ NO ☐ IS THE PATIENT HANDICAPPED? YES ☐ NO ☐

NAME OF SPOUSE	SOC. SEC. # OF SPOUSE	BIRTHDATE	SPOUSE EMPLOYER

IS THE PATIENT COVERED BY ANY OTHER DENTAL / VISION / DISABILITY PLAN? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

MEMBER NAME:	PLAN NAME AND ADDRESS:
RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ OTHER ☐ _____	GROUP PLAN #:
SOCIAL SECURITY # OF MEMBER:	EFFECTIVE DATE:

PATIENT OR PARENT MUST SIGN AND DATE BELOW

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.

X_____
Patient, or Parent if minor Date

IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):
I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X_____
Employee Date

PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "Employee Statement" section of the form (Part #1).
   - Questions regarding other coverage you or your dependents are eligible for must be answered.
   - Patient, or parent if minor, must always sign the "Authorization to Release Information". A claim cannot be processed without this authorization and verification.
   - If payment is to be made to the provider of services, you should sign that section.

2. **When not accompanied by an itemized bill** have your doctor or dentist complete PART 2 for each dental or vision claim

3. Attach all itemized bills relating to the claim to PART 1 of the Claim Form.
   - Make sure all bills identify the patient.
   - All bills should show the date of treatment, type of service, and amount of charges.

4. If you have other coverage (including Medicare), make sure you attach all Payment Statements, Explanations of Benefits or declination letters.

PLEASE COMPLETE AND SUBMIT PART 2 ONLY IF AN ITEMIZED BILL IS NOT SUBMITTED

PART 2 CLAIM FOR VISION EXAM, EYEGLASSES and / or CONTACT LENS

PATIENT'S NAME	BIRTH DATE OF PATIENT	RELATIONSHIP TO MEMBER SELF ☐ SPOUSE ☐ CHILD ☐
MEMBER'S NAME	MEMBER SSN	GROUP NUMBER

IS TREATMENT THE RESULT OF ILLNESS OR ACCIDENTAL INJURY? ☐ YES ☐ NO WORK RELATED? ☐ YES ☐ NO	IF YES TO EITHER, ENTER A BRIEF EXPLANATION INCLUDING DATES
DIAGNOSIS OR ICD-9 1. _____._____ 3. _____._____ 2. _____._____ 4. _____._____	IS THERE ANOTHER VISION BENEFIT PLAN? YES ☐ NO ☐ IF YES, PLEASE COMPLETE PART 1

DATE OF SERVICES			PLACE OF SERVICE	CPT/HCPCS	MOD	DESCRIPTION OF OPTICAL SERVICES RENDERED	CHARGES		UNITS	RENDERING PROVIDER NPI

FEDERAL TAX I.D. NUMBER	**TOTAL CHARGES**			
BILLING PROVIDER	**AMOUNT PAID**			
BILLING ADDRESS	**BALANCE DUE**			ACCEPT ASSIGNMENT? ☐ YES ☐ NO
CITY STATE ZIP	PATIENT ACCT #			