Simplified Benefits Administrators Claim Form

simplified benefits ADMINISTRATORS

☐ Medical	☐ Dental	☐ Vision

PLEASE COMPLETE FOR ALL MEMBER SUBMITTED CLAIMS.
ATTACH RECEIPTS AND ITEMIZED BILLS* TO THIS FORM.

Employee Information: Complete in all cases

Last Name	First Name	M.I.	Enrollee Number	Group Number

Street Address	City	State	Zip Code

Employer	Date of Birth (MM/DD/YY)	Gender	Marital Status
		☐ Male ☐ Female	

Dependent Information: Complete if dependent is the patient.

Name	Date of Birth (MM/DD/YY)	Relationship	Gender
		☐ Child ☐ Spouse ☐ Other	☐ Male Female

Is patient covered by another medical plan:

- ☐ Yes (If yes, attach a copy of the identification card)
- ☐ No

Employee Name	Name of Plan	Date of Birth (MM/DD/YY)	ID Number	Relationship

I certify that all information above is true to the best of my knowledge. I authorize the release of any medical or other information necessary to process this claim.

Employee Signature and Date: _____

Spouse Signature and Date: _____
(if spouse is patient)

AUTHORIZATION FOR DIRECT PAYMENT:
Sign **ONLY** if you want payment to go to the provider of service instead of coming directly to you.

Employee Signature and Date:_____
(REQUIRED for all claims)

Please submit claim and all documentation to:
Simplified Benefits Administrators
PO Box 4718
Englewood, CO 80155
Fax: 801.442.0041
Email: customerservice@simplifiedbenefitsadministrators.org

** Itemized bills must contain the following information: patient's name, date(s) of treatment, diagnosis, procedure code(s), location of service, fee for each service, provider name, provider address, provider tax identification number, provider NPI number.*