

**State of Oklahoma
HealthChoice**

**Statement of Claim
Group Health and Dental Plan**

A completed claim form must be submitted a minimum of once every year
to avoid any delay in processing. (PLEASE PRINT & COMPLETE EACH ITEM BELOW)

EMPLOYEE INFORMATION

1. Employee Name (first, middle init., last)	Employee's Social Security Number
2. Home Address (Street Address, City, State, Zip) Check If Change of Address _____	Home Phone Number ()
3. Employer	Work Phone Number ()

PATIENT INFORMATION

4. Patient's Name (first, middle init., last)

5. Relationship to Insured: ___ Self ___ Spouse ___ Child
If other than natural or legally adopted: ___ Stepchild ___ Foster ___ Other _____ (specify)

6. Birthdate (Month, Day, Year) Sex: _____ Male _____ Female

7. If Patient is a dependent 19-25 years old, is he/she a full-time student? _____ Yes _____ No. If yes, student must be full time and enrolled with 12 credit hours. Documentation must be submitted with enrollment and thereafter once a year by October 1.

8. Patient address if not same as employee's (Street Address, City, State, Zip)

9. Is patient totally disabled? _____ Yes _____ No Was condition related to patient's employment? _____ Yes _____ No

10. Was condition related to an accident? _____ Yes _____ No
If an accident, complete the following: _____ Date of Accident _____ Time _____ AM _____ PM
Describe how and where accident occurred _____

11. Are any members of your family employed _____ Yes _____ No If yes, complete the following:

Name	Relationship	Date of Birth	Social Security No.	Employer Name and Address:

12. **New members need to submit a HIPPA certificate of creditable coverage from the previous insurer, if applicable.**

13. Does employee or any family member have other group health insurance? _____ Yes _____ No
Type of coverage: _____ Medical _____ Dental _____ Vision _____ Prescription Drugs
Type of Insurance: _____ Other group health insurance _____ Medicare
NAME & ADDRESS OF OTHER INSURANCE CARRIER OR ADMINISTRATOR Plan Effective Date Plan Number

REQUEST TO RELEASE INFORMATION

14. I hereby request and authorize any hospital, physician, or the person who has attended or examined me, to furnish to the State Employee's Group Health and Life Insurance Board or its representative, any and all information concerning any illness or injury I may have suffered, medical history, consultation, prescription, treatments including x-ray plates or the proofs of loss submitted by me to the Board. NOTICE: INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ON COMMNICABLE OR VENEREAL DISEASES SUCH AS HEPATITUS, SYPHILIS, GONORRHEA, HIV/AIDS (HUMAN IMMUNE DEFICIENCY VIRUS/ ACQUIRED IMMUNE DEFICIENCY SYNDROME) OR ANY OTHER CONDITIONS FOR WHICH I MAY HAVE BEEN TREATED WHILE A PATIENT.

Date _____ Patient's or Authorized Person's Signature _____

15. EMPLOYEE'S SIGNATURE _____ Date _____

(SEE REVERSE SIDE FOR IMPORTANT INFORMATION)

INSTRUCTIONS FOR COMPLETION OF CLAIM FORM

1. Name of employee, retiree, vested, or disability, survivor, or COBRA enrollee and social security number.
2. Home address of covered member or dependent. (Please check if it is a new address. It is important to have your current address in order to send checks or Explanation of Benefits forms.) Also, indicate employee's home phone number.
3. It is important to give the name of the employer(s) through which you have insurance coverage. If you are retired this information is not necessary. If you have more than one employer please indicate. Also, indicate a work phone number.
4. List patient's name.
5. Relationship to the employee.
6. Patient's birth date and sex.
7. Is dependent a full-time student? (Student status information is due by October 1 each year).
8. Patient address if not same as employee's.
9. If patient is disabled, complete 10 through 13. Was condition related to patient's employment?
10. Related to an accident? When, where, how?
11. Are other family members employed?
12. This applies to new members only.
Send certificates to: OSEEGIB HIPAA Unit, 3545 NW 58th Street, Suite 500, OKC, OK 73112
13. Other group health insurance? If yes, list individuals covered if not the same as 11 and name of other insurance.
14. Release of information signature required from patient only.
15. Employee signature required.

MAILING INSTRUCTIONS

Harrington Benefits
P.O. Box 24870
Oklahoma City, Oklahoma 73124-0870

FOR ALL QUESTIONS REGARDING HEALTH & DENTAL CLAIMS CALL:

HealthPlan Services, Inc.

Oklahoma City
Nationwide

405-499-4920
800-782-5218

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**NOTE! FOR YOUR PROTECTION: RETAIN A COPY OF ALL MATERIAL
MAILED BY YOU TO YOUR GROUP INSURANCE PROGRAM.**