

St. Lawrence-Lewis Counties School District Employees Medical Plan
P.O. Box 697
Canton, NY 13617
(315) 379-3000
1-(800)-722-0782 toll free

CLAIM FORM

Employer's (School District) Name: _____

Employee's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Group #: _____ Emp. #: _____

Patient's Name: _____ Date of Birth: _____

Relationship (circle one): self spouse dependent child

Nature of Illness: _____

Is Claim Based On An Accident? ☐ yes ☐ no Date And Time Of Accident: _____

Description of Accident: _____

Accident Happen While Working? ☐ yes ☐ no

Auto Accident? ☐ yes ☐ no

Other? ☐ yes ☐ no

Do You Or Any Of Your Family Members Have Any Other Health Insurance? ☐ yes ☐ no

If yes, please check subscriber of other insurance: ☐ SELF ☐ SPOUSE ☐ OTHER _____

Name and Address of Insurance Company(s) _____

Policy # _____ Group # _____ Name of Employer _____

Effective Date of coverage: _____

**Type of Plan (please check all that apply): ☐ HMO ☐ High Deductible Health Plan ☐ Major Medical

☐ Medicare ☐ Medicare Supplement ☐ HSA(Health Savings Acct) / HRA(Health Reimbursement Acct)

☐ Preferred Provider ☐ Medicaid ☐ Family/Child Health Plus ☐ Other _____

Authorization To Release Information: I hereby authorize Healthcare Administrative Services to release or obtain information which may be necessary to determine benefits payable under the Plan. A photocopy of this authorization shall be valid.

Employee Signature: _____ Date Signed: _____

Assignment: I hereby authorize payment directly to the hospital, physician or dentist herein named. I understand I am financially responsible for charges not covered by this assignment.

Employee Signature: _____ Date Signed: _____