Medical Claim Form

Complete and submit to
Maxor Administrative Services

Mail Claim to:
P.O. Box 15050
Amarillo, TX 79105

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully iternized bill. A diagnosis must be shown on the bill.

EMPLOYEE INFORMATION: | GROUP NAME, #:

Name (last, first, initial)		Sex	Employer Name	
Home Address		Identification Number	Birthdate	Group Number
City	State	Zip Code	Work Telephone ( )	Home Telephone ( )

PATIENT INFORMATION:

The patient is: ☐ **EMPLOYEE** ☐ **SPOUSE** (complete spouse information) ☐ **DEPENDENT CHILD** (complete spouse and child information)

Spouse's Name (last, first, initial)		Sex	Child's Name (last, first, initial)	Sex
Spouse's Birthdate	Spouse's SSN		Child's Birthdate	Child's SSN
Spouse's Employer				
Spouse's Employers' Address				

DOES ANYONE HAVE ANY OTHER COVERAGE?

☐ **YES** (then complete) ☐ **NO** (go to next section)

NAME OF POLICYHOLDER:

Name of Other Health Insurance Carrier or Plan	Address	City	State	Zip Code
Other Insurance Carrier's or Plan's Telephone No.	Type of Coverage ☐**GROUP** ☐**INDIVIDUAL**	Group Number	Contract or Policy Number	
Spouse's Employer	If child is over age 19 and full-time student, complete: Name of School:			
Spouse's Employer's Address	School Address:			

ABOUT THIS CLAIM

☐INJURY ☐ILLNESS

Date and time of accident:

Describe injury, when and how it happened or nature of illness:

Was injury the result of auto accident? ☐ YES ☐ NO

If auto insurance involved, please provide: Policy No. | Name of Insurance Company | Address (City, State, ZIP Code)

Did you or the patient receive, seek, or will be seeking monetory recovery for accident/injury? ☐ YES ☐ NO

Work related injury? ☐ YES ☐ NO

If injury is work related, please contact your employer for proper instructions regarding this claim.

EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED - Authorization to release information

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release of obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature ______________________________ Date ____________