Lifetime Benefit Solutions Medical and Prescription Drug
HEALTH INSURANCE CLAIM FORM
THIS IS *NOT* TO BE USED FOR FLEXIBLE SPENDING ACCOUNT CLAIMS

EMPLOYEE NAME:____

MEMBER IDENTIFICATION NUMBER: _____________________________________
(From Benefit ID Card)

PATIENT'S NAME (If different from Employee): ___________________________ Patient Date of Birth: ____________

Is this claim the result of an accident? ☐Yes ☐No

If yes, please give a brief description:

____

____

Are you or any of your dependents covered under another plan? ☐Yes ☐No

If yes, Name of Plan: ____

Please send all claims to:

Lifetime Benefit Solutions
ATTN: Group Health Claims
PO Box 780
Liverpool, NY 13088-0780
Fax: 448-9132

Check One:

☐ Pay Employee ☐ Pay Provider

Make sure all enclosed bills list the date(s) of service, charges itemized, and diagnosis. If a prescription claim, receipts must include NDC numbers for each prescription.

SIGNATURE: ____ DATE: ___________________