MAIL COMPLETED CLAIM FORM AND ITEMIZED BILLS TO:

CORESOURCE, INC.
POST OFFICE BOX 2920
CLINTON, IA 52733-2920

(All claims not submitted within twelve (12) months from the date the services were rendered will not be a *covered expense* and will be denied) Refer to your SPD for additional details.

MEDICAL CLAIM FORM

EMPLOYEE INFORMATION	Employer's Name: _____ Employee's Name: _____ Date of Birth: _____ Phone Number: _____ Current Mailing Address: _____ _____	Group #: _____ Social Security #: _____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married
SPOUSE INFORMATION	Spouse's Name: _____ Name of Employer: _____ Employer's Address: _____ _____	Social Security #: _____ Gender: ☐ Male ☐ Female Date of Birth: _____
PATIENT INFORMATION	Patient's Name: _____ Date of Birth: _____ Describe condition, illness or injury **(if accident, state where, how, date it occurred and if it was work related):** _____ _____ _____	Social Security #: _____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married Relationship to Employee: _____
COORDINATION OF BENEFITS	**OTHER GROUP MEDICAL COVERAGE (This section must be completed).** 1. Is the patient eligible for benefits under any other group medical plan? ☐ Yes ☐ No 2. If the answer to the above is "yes", please provide: Name and address of organization providing coverage: _____ _____ Policy / Group Number: _____ Name and address of location where claims are to be processed: _____	
DIRECT PAYMENT	**ASSIGMENT OF BENEFITS** I hereby authorize payment directly to _____ of the medical benefits due under this group policy, not to exceed the eligible charges submitted. I understand that I am financially liable for charges not covered by this authorization. This assignment is valid only for expense(s) accompanying this form and the Assignee indicated. **Employee Signature**: _____ Date: _____	
AUTHORIZATION	I AUTHORIZE the disclosure of relevant information about me for the purpose of evaluation and administering my claim. I AUTHORIZE the following to disclose such information: any physical, medical professional, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, consumer reporting agency, medical or hospital service, prepaid health plan, employer, group policyholder, contract holder or benefit plan administrator. They may disclose such information to CoreSource, its reinsurers, consumers, reporting agency, attorney, agent or independent administrator action on its behalf. I UNDERSTAND that relevant information for claims purposes includes employment-related information about medical care, advice, diagnosis, treatment, supplies provided, mental illness, and dug or alcohol use. I UNDERSTAND that CoreSource will not release this information EXCEPT to reinsuring companies, to other persons or organizations performing business or legal services in connection with my claim, or as the law otherwise requires or permits. I KNOW that a photographic copy of this Authorization shall be valid as the original... I AGREE that this Authorization shall be valid as follows: 1) for Claims of Health Insurance Benefits, for 18 months from the date shown below or for the term of coverage of the policy, whichever is shorter; or 2) for all other claims for 18 months from the date shown below for the duration of the claim, whichever is shorter. I WARRANT that the information furnished on this claim form is accurate and complete and that providing false or misleading information is illegal. **SIGN HERE (Employee):** _____ Date: _____	