Med-Pay, Inc.

P.O. Box 10909
Springfield, MO 65808

(417) 886-6886
1-800-777-9087

THIS SHORT FORM CLAIMS SUBMITTAL SHEET CANNOT BE USED FOR THE FIRST CLAIM OF THE CALENDAR YEAR OR FOR ANY ACCIDENT CLAIMS. (PLEASE USE THE STANDARD CLAIM FORM FOR THESE CLAIMS.)

EMPLOYER NAME: **GROUP NO.:**

Employee Name (Please Print): Social Security Number:

Address (Complete only if changed) Street:

City: State: ZIP Code:

This Claim is On (Name): ☐ Myself ☐ Spouse ☐ Dependent Child

If this claim is on a dependent child who is age 18 or over, your plan requires that the child be a full-time student to be eligible for benefits. Please provide the following information.

Child's Date of Birth:

School Name: School Address:

If any of your dependents (spouse or child) is employed, please complete the following.

Dependent's Name:

Name of Employer:

Policy Name/Number:

Address:

Telephone Number:

I HEREBY AGREE TO REIMBURSE MY EMPLOYER TO THE EXTENT OF ANY OVERPAYMENT WHICH IS IN EXCESS OF THE AMOUNT PAYABLE UNDER THE PLAN. THE STATEMENTS ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY BELIEF. I AUTHORIZE ANY HOSPITAL OR PHYSICIAN TO FURNISH ANY INFORMATION REQUESTED. ALSO, I HEREBY AUTHORIZE MY EMPLOYER OR MED-PAY, INC. TO RELEASE OR OBTAIN FROM ANY ORGANIZATION OR PERSON ANY INFORMATION WHICH MAY BE NECESSARY TO DETERMINE BENEFITS PAYABLE UNDER THE PLAN WITH MY EMPLOYER. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____
EMPLOYEE'S SIGNATURE/DATE

_____
PATIENT'S SIGNATURE/DATE (If patient is not Employee)

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN OR SUPPLIER FOR SERVICES.

_____
SIGNATURE (Employee or Authorized person)

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