Med-Pay, Inc.

P.O. Box 10909
Springfield, MO 65808
Fax: (417) 890-0741
Email: fax@med-pay.com

Short Claim Form

Complete and attach this form to your claim and submit by mail, fax or email (listed above).

Note: If needed, an Accident Claim Form is available on www.med-pay.com under Resources/For Employees.

Group #:		**Employer Name:**	
Employee Name:			
Date of Birth:		**Medical ID #:**	
Claimant Name:			
Date of Birth:		**Relationship to Employee:**	◯ Self ◯ Spouse ◯ Child
Employee Address	_____ _____ ____ _____ Address City State Zip Any changes must be submitted through Human Resources.		

Did you pay the provider for these services? ◯ Yes ◯ No

If "No", I authorize payment of benefits to the provider. _____ (initial)

_____ _____
Employee's Signature (Print and sign or use Adobe digital signature)

_____
Date

If you have any questions, contact Med-Pay's Customer Service Department:
(417) 886-6886 or (800) 777-9087