CRESCENT
HEALTH SOLUTIONS

Health Plan Reimbursement Request Form

SECTION I: EMPLOYEE, EMPLOYER, PATIENT INFORMATION (Please answer all questions and print clearly.)

GROUP #: _____ NAME OF EMPLOYER: _____

EMPLOYEE NAME: _____ EMPLOYEE DATE OF BIRTH: _____

EMPLOYEE ADDRESS: _____ CONTACT PHONE #: _____

SOCIAL SECURITY NUMBER (Last 4 digits): _____

ARE YOU STILL EMPLOYED BY THIS COMPANY? ☐ YES ☐ NO IF NO, DATE OF TERMNATION: _____

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

PATIENT SEX: ☐ FEMALE ☐ MALE MARITAL STATUS: ☐ MARRIED ☐ SINGLE

PATIENT'S RELATIONSHIP TO EMPLOYEE: ☐ SELF ☐ SPOUSE ☐ CHILD (UNDER 19) ☐ CHILD (FULL-TIME STUDENT)

☐ HANDICAPPED ☐ STEP CHILD. IF STEP CHILD, DOES CHILD RESIDE IN YOUR HOME? YES ☐ NO ☐

OTHER HEALTH INSURANCE

DO YOU, YOUR SPOUSE (WHETHER MARRIED OR DIVORCED), OR ANY OF YOUR DEPENDENT CHILDREN HAVE ANY OTHER INSURANCE OF THE TYPES LISTED BELOW? (Please answer each question.)

EMPLOYER ☐ YES ☐ NO GOVERNMENT PLAN ☐ YES ☐ NO STUDENT SCHOOL POLICY ☐ YES ☐ NO

UNION ☐ YES ☐ NO ASSOCIATION PLAN ☐ YES ☐ NO ANY OTHER PLAN ☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING INFORMATION. NAME AND ADDRESS OF COMPANY PROVIDING BENEFITS:

_____

POLICY #: _____ INSURED NAME: _____

INSURED SOCIAL SECURITY # (LAST 4 DIGITS): _____ INSURED DATE OF BIRTH: _____

COMPLETE WHEN AN ACCIDENT IS INVOLVED

DATE OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

DESCRIBE ACCIDENT IN DETAIL: _____

_____

IF ACCIDENT WAS RELATED TO YOUR EMPLOYMENT, EXPLAIN:

_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE ALL DOCTORS, HOSPITALS, OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH CRESCENT TPA SERVICES WITH FULL INFORMATION REGARDING TREATMENT RENDERED (INCLUDING COPIES OF THEIR RECORDS). I ALSO AUTHORIZE CRESCENT TPA SERVICES TO OBTAIN FROM, OR RELEASE TO, ANY UNION, TRUST FUND, EMPLOYER OR INSURANCE CARRIER ALL INFORMATION REGARDING BENEFITS TO WHICH I, OR ANY OF MY DEPENDENTS, MAY BE ENTITLED.

SPOUSE SIGNATURE: _____ DATE: _____
(if claim is on spouse or there is Other Insurance)

EMPLOYEE SIGNATURE: _____ DATE: _____

PLEASE COMPLETE THIS FORM AND FAX OR SEND TO ATTENTION: TPA AT 828-670-9155.

Crescent Health Solutions 1200 Ridgefield Blvd. Ste. 215 Asheville NC 28806-2292 Telephone 828-670-9145 Fax 828-670-9155