EMPLOYEE DEPENDENT CLAIM FORM

Submission Options

Fax (417) 883-8261 | **Email** claims@gbsitpa.com | **Online** mygbshealth.com

EMPLOYEE INFORMATION

*This section **must be completed for all claim submissions.** This section must be **completed by the employee only.***

Name: ______________________ **Employer:** ______________________

Last 4 of SSN: ____________ **Date of Birth:** ____________

Home Address: ____

Street Address *City* *State* *Zip*

DEPENDENT INFORMATION

Only complete** this section **for a dependent claim submission.

Dependent's Name: ______________________ **Date of Birth:** ______________

CLAIM INFORMATION

Complete** this section **for all claim submissions.

Do you and/or your dependent have medical coverage other than GBS? Y / N

What type of claim is being submitted? Medical / Dental / Vision

If you're ***submitting a medical claim,*** attach the following information on the service provider's letterhead:

- ☐ Provider's federal tax ID number
- ☐ Diagnosis codes
- ☐ Description of service(s)
- ☐ Date(s) of service

If you're ***submitting a dental or vision claim,*** attach the following information on the service provider's letterhead:

- ☐ An itemized list of service(s) received with cost per service
- ☐ Name of the provider where service(s) were received
- ☐ Date(s) of service

AGREEMENT AND SIGNATURE

I/We certify that the above information is true and correct. I/We authorize the release of any medical or other information necessary to evaluate and complete the review and processing of any claims for reimbursement. A photocopy of this authorization shall be considered as valid as the original.

Signature of Employee: ______________________ **Date:** ____________

Signature of Spouse (if patient): ______________________ **Date:** ____________

NOTICE: The information contained in this claim form, and any attachments accompanying this transmission, may be legally privileged and/or confidential and protected health information. This information is intended only for use of the individual(s) and/or entity identified above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to protect the information after its stated need has been fulfilled. If you are not the intended recipient, or any employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, printing, copying, forwarding, or distributing of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately, by telephone or return email, to advise of wrongful receipt and confirm your understanding of this Notice. Thank you.