



Lifetime Benefit Solutions Medical and Prescription Drug  
HEALTH INSURANCE CLAIM FORM  
THIS IS NOT TO BE USED FOR FLEXIBLE SPENDING ACCOUNT CLAIMS

EMPLOYEE NAME: \_\_\_\_\_

MEMBER IDENTIFICATION NUMBER: \_\_\_\_\_  
(From Benefit ID Card)

PATIENT'S NAME (If different from Employee): \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Is this claim the result of an accident?  Yes  No

If yes, please give a brief description:

\_\_\_\_\_  
\_\_\_\_\_

Are you or any of your dependents covered under another plan?  Yes  No

If yes, Name of Plan: \_\_\_\_\_

Please send all claims to:

Lifetime Benefit Solutions  
ATTN: Group Health Claims  
PO Box 780  
Liverpool, NY 13088-0780

Check One:

Pay Employee  Pay Provider

**Make sure all enclosed bills list the date(s) of service, charges itemized, and diagnosis. If a prescription claim, receipts must include NDC numbers for each prescription.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_