Cayuga-Onondaga Area School Employees' HEALTHCARE PLAN

EMPLOYEE PAID EXPENSE HEALTH PLAN CLAIM FORM FOR MEDICAL AND PRESCRIPTION CLAIMS*

(This form is NOT to be used for Flexible Spending Account Claims)

EMPLOYER NAME:_____

EMPLOYEE NAME:_____

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
P.O. BOX 21951
EAGAN, MN 55121
or FAX to ONE of the following (315) 448-9132; (877) 249-5255; (888) 379-6245

Check One: ☐ Pay Employee ☐ Pay Provider

MAKE SURE ALL ENCLOSED BILLS LIST

- **Date(s) of Service**
- **Itemized Charges**
- **Diagnosis Code**
- **Name and Tax ID of the Provider Rendering Service**

IF A PRESCRIPTION CLAIM - Include Pharmacy receipt with NDC Number

SIGNATURE: _____ DATE: _____

*****Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claiming containing any materially false information, or conceals to the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.