

CLAIM FORM

1. COMPLETE THIS FORM IN FULL AND SIGN BELOW.
2. ATTACH ALL BILLS.
3. MAIL TO:

Fringe Benefit Coordinators
 P O BOX 5249
 Gainesville, FL 32627-5249

**NORTH EAST FLORIDA
 EDUCATIONAL CONSORTIUM**
 FRINGE BENEFIT COORDINATORS
 1239 NW 10TH Ave
 Gainesville, FL 32601
 (352) 377-1239 Fax (352) 372-9805
WWW.FBC-INC.COM



PART 1 EMPLOYEE STATEMENT PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME			SOCIAL SECURITY #		NAME OF DISTRICT		
EMPLOYEE MAILING ADDRESS				EMPLOYEE BIRTH DATE	OCCUPATION		GROUP NUMBER NEF _____
CITY	STATE	ZIP	PHONE NO.	EMAIL ADDRESS (OPT)		NAME OF SCHOOL	
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH		IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH		IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH		IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IS THE PATIENT A FULL TIME STUDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			IS THE PATIENT HANDICAPPED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
NAME OF SPOUSE		SOC. SEC. # OF SPOUSE		BIRTHDATE	SPOUSE EMPLOYER		
IS THE PATIENT COVERED BY ANY OTHER DENTAL / VISION / DISABILITY PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE THE FOLLOWING:							
MEMBER NAME:				PLAN NAME AND ADDRESS:			
RELATIONSHIP TO PATIENT: SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER <input type="checkbox"/> _____				GROUP PLAN #:			
SOCIAL SECURITY # OF MEMBER:				EFFECTIVE DATE:			

PATIENT OR PARENT MUST SIGN AND DATE BELOW

IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____
 Patient, or Parent if minor Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):

I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
 Employee Date

PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "Employee Statement" section of the form (Part #1).
 - Questions regarding other coverage you or your dependents are eligible for must be answered.
 - Patient, or parent if minor, must always sign the "Authorization to Release Information". A claim cannot be processed without this authorization and verification.
 - If payment is to be made to the provider of services, you should sign that section.
2. **When not accompanied by an itemized bill** have your doctor or dentist complete PART 2 for each dental or vision claim
3. Attach all itemized bills relating to the claim to PART 1 of the Claim Form.
 - Make sure all bills identify the patient.
 - All bills should show the date of treatment, type of service, and amount of charges.
4. If you have other coverage (including Medicare), make sure you attach all Payment Statements, Explanations of Benefits or declination letters.

PLEASE COMPLETE AND SUBMIT PART 2 ONLY IF AN ITEMIZED BILL IS NOT SUBMITTED

PART 2 CLAIM FOR VISION EXAM, EYEGLASSES and / or CONTACT LENS

PATIENT'S NAME				BIRTH DATE OF PATIENT		RELATIONSHIP TO MEMBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>			
MEMBER'S NAME				MEMBER SSN		GROUP NUMBER			
IS TREATMENT THE RESULT OF ILLNESS OR ACCIDENTAL INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF YES TO EITHER, ENTER A BRIEF EXPLANATION INCLUDING DATES					
DIAGNOSIS OR ICD-9 1. _____ 3. _____ 2. _____ 4. _____				IS THERE ANOTHER VISION BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>					
				IF YES, PLEASE COMPLETE PART 1					
DATE OF SERVICES		PLACE OF SERVICE	CPT/HCPCS	MOD	DESCRIPTION OF OPTICAL SERVICES RENDERED	CHARGES		UNITS	RENDERING PROVIDER NPI
FEDERAL TAX I.D. NUMBER					TOTAL CHARGES				
BILLING PROVIDER					AMOUNT PAID				
BILLING ADDRESS					BALANCE DUE		ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
CITY			STATE	ZIP	PATIENT ACCT #				