GROUP HEALTH CLAIM FORM

P.O. Box99906
Grapevine, Texas 76099
FAX (469) 417-1960

LSU First Health Plan **GROUP NUMBER** **LSUFIRST**

Claim submitted with completed Group Health Claim Form is for: ☐ *Employee* ☐ *Spouse* ☐ *Dependent*

PLEASE COMPLETE FORM COMPLETELY. A GROUP HEALTH CLAIM FORM MUST BE COMPLETED FOR EACH CLAIM SUBMITTED. ATTACH ALL BILLS/CORRESPONDENCE IF YOUR PHYSICIAN IS NOT FILING THE CLAIM FOR YOU. IF CLAIM IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THE OTHER INFORMATION SECTION OF THIS FORM. ONCE YOU HAVE COMPLETED THE FORM, YOU MAY MAIL IT TO PO BOX 99906 GRAPEVINE, TX 76099, FAX IT TO 469-417-1960 ATTN: CLAIMS, OR EMAIL TO LSUSERVICE@WEBTPA.COM. CLAIMS MUST BE RECEIVED WITHIN 90 DAYS FROM THE DATE OF SERVICE.

EMPLOYEE'S INFORMATION

Employee Name _____ Date of Birth _____

Social Security Number _____ Gender (check one) ☐ Male ☐ Female

Are you presently employed? (check one) ☐ Yes ☐ No If yes, give name and address of employer

If not presently employed, please check which apply: _____

☐ Retired ☐ COBRA _____

SPOUSE'S INFORMATION

Spouse Name _____ Date of Birth _____

Social Security Number _____ Gender (check one) ☐ Male ☐ Female

Are you presently employed? (check one) ☐ Yes ☐ No If yes, give name and address of employer

If not presently employed, please check which apply: _____

☐ Retired ☐ COBRA _____

DEPENDENT INFORMATION

Dependent Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Gender (circle one)	Full-Time* Student (if over age 18)	Disabled**
			Male / Female	☐ Yes ☐ No	☐ Yes ☐ No

***** Please provide updated disability information that was filed with Social Security.***

ADDITIONAL INFORMATION

Is the patient covered by other insurance?
☐ Yes ☐ No
If yes, complete the following information:

Insured Name _____

Insured Company Name _____

Policy Number _____

Policy Effective Date _____

Place, Date, and Description of Accident/Remarks:

_____

_____

_____

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_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, EMPLOYERS, AND OTHER PERSONS OR INSTITUTIONS. This authorizes you to give WebTPA, or its authorized representative who is employed to assist in the evaluation of my claim, any information, date or records you may have regarding me, my employment or my condition (including records pertaining to psychiatric, drug or alcohol use history, and any disability I may have had). I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to an agency or person employed by WebTPA. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photocopy of this authorization may be accepted as effective and valid as the original. By signing, this form, I submit my annual information review and initial claim authorization. I understand that claims submitted under this authorization will be processed subject to continued proof of eligibility and all plan provisions. I verify that the information on the entire form is correct.

Patient/Authorized Person's Signature _____ Date _____

Employee's Signature _____ Date _____

Employee's Mailing Address _____

Street City State Zip