Alliance Coal Health Plan

Claims Address:
PO Box 1950
Tulsa, OK 74101-1950

HEALTH CLAIM FORM

Group Number: 2008ALC

Claim submitted with completed Alliance Coal Health Claim Form is for (circle one): ***Employee*** ***Spouse*** ***Dependent***

PLEASE COMPLETE FORM COMPLETELY. A 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.

EMPLOYEE'S INFORMATION

Employee Name

Date of Birth _____

Member ID # (example: ACZ8300XXXXX-XX)

Gender (check one) ☐ Male ☐ Female

Are you currently employed? (check one)
☐ Yes ☐ No

If yes, give name and address of employer
_____
_____

SPOUSE'S INFORMATION

Spouse Name

Date of Birth _____

Member ID # (example: ACZ8300XXXXX-XX)

Gender (check one) ☐ Male ☐ Female

Are you currently employed? (check one)
☐ Yes ☐ No

If yes, give name and address of employer
_____
_____

DEPENDENT INFORMATION

Dependent Name (First, Middle Initial, Last)	Member ID # (example: ACZ8300xxxxx-xx)	Date of Birth	Gender (Circle One)
			Male Female

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
_____
_____
_____
_____

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 Alliance Coal Health Plan, 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 Alliance Coal Health Plan. 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 this entire form is correct.

Patient/Authorized Person's Signature_____ Date _____

Employee's Signature_____ Date _____

Employee's Mailing Address _____
Street City State Zip