Member Medical Bill Claim Form

Please use a separate claim form for each patient bill. Your cooperation in completing all items on the claim form and attaching a copy of the provider's bill will help expedite quick and accurate claim processing. SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS.

Section A: PATIENT INFORMATION

Last Name:	First Name:		MI:
Does the Patient have other insurance coverage? ☐ Yes ☐ No	Relation to Member: ☐ Self ☐ Spouse or DP ☐ Child | Dependent	Sex: ☐ M ☐ F	Date of Birth: (MM/DD/YYYY) / /
Name of PATIENT'S other insurance company:	Group Number:	Other Employer Name:	Policy Number:

Section B: EMPLOYEE INFORMATION (From insurance card)

Last Name:	First Name:	MI
Street Address:	City | State:	Zip:
Home Phone:	Work Phone:	Date of Birth: (MM/DD/YYYY) / /
Employer Name:	Group Number:	Employee ID Number:

Section C: MEDICAL INFORMATION

Use this section to report any COVERED provider service that has not already been reported to the Trust by the provider (the physician, clinical, ambulance company, Rx, etc.) Attach a copy of the itemized bill. Please be sure that duplicate bills are not submitted.

NOTE: To properly process your claim a copy of the itemized bill from your provider must be attached.

Each itemized bill must include the following information:

- Name and address of Provider (Doctor, hospital, lab, etc.)
- Name of patient receiving services
- Service provided
- Date of service
- Amount Charged for each service
- Diagnosis Code
- Procedure Code
- Provider Tax ID number

NOTE: Balance due statements are not able to be processed – specific billing information must be included.

Was this medical expense the result of an accident?..... ☐ Yes ☐ No

Was this condition or injury job related?..... ☐ Yes ☐ No

If yes, have you filed for Workers' compensation?..... ☐ Yes ☐ No

If it was an accidental or work injury, when did this injury or accident occur? (MM/DD/YYYY) ____/____/_____ Time: _____

I certify that, to the best of my knowledge, the information on this Member Medical Bill Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.

Signature:	Name:	Date: (MM/DD/YYYY) / /

Submit this completed form and copies of your bill to:

Western Grocers Employee Benefits Trust c/o Cypress Benefit Administrators
▪ PO Box 22166 ▪ Portland, OR 97269
Or FAX: 503.968.2817
For additional copies of this form go to www.WesternGrocersTrust.com

HOW TO USE THIS FORM

Dear Employee:

Usually, health care providers bill us directly for services to you and your enrolled dependents. This is the preferred claim payment procedure. In this way it is not necessary for you to complete claim forms and we often need more details than are ordinarily provided on the provider bills sent to patients.

Sometimes, you may choose to pay cash for services, or for some reason a provider may not bill us and send the bill directly to you. In either instance, we have no way of knowing about your claim.

This Member Medical Bill Claim Form was developed to assist you in notifying us of any covered health service for which we have not already been billed. And to request reimbursement if you have already paid the provider.

Please read the following instructions about how to report Health Care Services.

We are happy to serve you.

SECTION A. PATIENT INFORMATION

Use this section to identify the patient.

SECTION B. EMPLOYEE INFORMATION (on your benefits card)

Use this section to identify the subscriber. Most of this information may be found on your Western Grocers Employee Benefits Trust member card.

SECTION C. MEDICAL INFORMATION (Health Care Services):

Use this section to report any COVERED health service that has not already been reported to the Trust by the provider of service (the physician, clinical services, ambulance company, Rx, etc.)

Attach a copy of the provider's itemized bill. Please be sure that duplicate bills are not submitted.

Submit this completed form and copies of your bill to:

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