Health Insurance Claim Form

Insured Information		
Policy number:	Certificate number:	Employer:
Insured last name:	First name:	Middle name:
Address:		
Parish:		Postal code:
Home phone:	Cell phone:	Work phone:
Email:		
DOB: (DD/MM/YYYY) / /		

Patient Information		
Patient last name:	First name:	Middle name:
Address: (If not the same as Insured)		
Parish:		Postal code:
Home phone:	Cell phone:	Work phone:
Email:		
DOB: (DD/MM/YYYY) / /		
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Gender: ☐ Male ☐ Female		
If you have any other health insurance coverage, please provide name of policy holder and policy number:		

Claim Information

Is the treatment as a result of: (please provide dates and details)

☐ Work place injury ☐ Motor vehicle accident ☐ Pregnancy ☐ Other

Date of service	Place of service	Description of service	Name of provider or facility	Amount claimed (attach receipts)

Declaration: I certify that all expenses for which reimbursement is requested from BF&M have been incurred and have not been reimbursed and are not reimbursable under any other health plan. I understand that I am required to submit, in addition to this claim form, an itemized receipt from a merchant or an explanation of benefits from the health care professional. I represent that any individual (other than the employee or employee's spouse) for whom a claim is filed hereunder, qualifies as an eligible dependent of the employee as defined in your plan documents.

Subscriber's signature: ______________________ Date: ______________________