UNIFIED GROUP SERVICES, INC.

Toll Free 1-800-291-5837
Local (765) 778-1535
Provider Benefit FaxBack (888) 239-2940
Internet Info https://www.ugsweb.com

BENEFIT CLAIM FORM

PLEASE MAIL COMPLETED FORM TO:

Unified Group Services, Inc.
P.O. Box 10
Pendleton, IN 46064

Employee Name: _____ S.S.# _____

Address: ☐ Check Box If New Address Group # _____

Street _____ City _____ State ____ ZIP _____

_____ _____

Patient's First Name, Initial, and Last Name — Date Of Birth

IN ADDITION TO THIS MEDICAL COVERAGE, IS PATIENT COVERED UNDER ANY OTHER MEDICAL INSURANCE? ☐YES ☐ NO

IF YES, PLEASE PROVIDE:

NAME OF EMPLOYEE: _____ (_____)
Employee Date Of Birth

NAME OF EMPLOYER: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

POLICY NUMBER: _____

PROVIDER OF SERVICES: Attach Itemized Provider Bills.

Name In Full	Address and Phone No.
1 _____	_____
2 _____	_____
3 _____	_____

IS ILLNESS OR INJURY DUE TO EMPLOYMENT? ☐ YES ☐ NO

IS THIS THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE THE ACCIDENT SECTION ON BACK OF FORM.

FOR PROMPT CLAIMS PAYMENT, COMPLETE ALL SECTIONS OF THIS CLAIM FORM AND ATTACH THE ITEMIZED BILL(S) FROM YOUR PHYSICIAN. CLAIMS FOR PRESCRIPTIONS MUST INCLUDE AN ORIGINAL PHARMACY RECEIPT. FOR QUESTIONS, CONTACT UNIFIED GROUP SERVICES, INC. AT (800) 291-5837.

PLEASE TURN OVER

IF THESE CHARGES ARE A RESULT OF AN ACCIDENT, PLEASE ANSWER THE FOLLOWING QUESTIONS:

DESCRIBE THE ACCIDENT

- HOW IT HAPPENED: _____

_____

- WHEN IT HAPPENED: _____

- WHERE IT HAPPENED: _____

- WAS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

IF YES, PLEASE ATTACH A COPY OF THE POLICE ACCIDENT REPORT

- IS ANYONE ELSE RESPONSIBLE FOR THESE CHARGES? ☐ YES ☐ NO

IF YES, WHO? _____

- WHAT ARE THE INJURIES? _____

_____

EMPLOYEE CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HEREUNDER IS TRUE AND CORRECT AND THAT THE EXPENSES WERE INCURRED BY THE NAMED PATIENT AND AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, OR PROVIDER OF SERVICE TO RELEASE TO UNIFIED GROUP SERVICES, INC. PRIOR TO OR AFTER PAYMENT, ANY AND ALL INFORMATION RELATED TO THIS CLAIM.

DATE: _____ SIGNATURE: _____
EMPLOYEE

SIGNATURE: _____
PATIENT, IF SPOUSE

AUTHORIZATION FOR PAYMENT:

I AUTHORIZE UNIFIED GROUP SERVICES, INC. TO PAY THE PROVIDER DIRECTLY FOR THE MEDICAL SERVICES RENDERED BY THE PROVIDER.

EMPLOYEE SIGNATURE: _____