CLAIM FOR HEALTHCARE BENEFITS

P.O. Box 53428 Lubbock, TX 79424 • Phone: 888-803-0081 • Fax: 806-698-5283 • Customer Service Email: careconnect@90degreebenefits.com

To complete submission for reimbursement this form and receipts are required.

Employer | Group No. | Employee Name

Employee Birthdate | Employee Social Security No. | Gender | Work Status | ☐ COBRA

Employer Name or Group No. | ☐ Male ☐ Female | ☐ Active ☐ Retired

Home Address (Apt No.) (City) (State) (Zip)

Home Phone No. | Employee Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Legally Separated

If "Yes" (Name, Address and Phone No. of Spouse's Employer) Yes☐ No ☐

Address

Phone No. (Apt No.) (City) (State) (Zip)

Patient Name | Date Covered | Relationship to Employee

If Patient is a Child, are they Married? ☐ Yes ☐ No | Patient Birthdate | ☐ Self ☐ Spouse ☐ Child

If Patient is a Child Over Age 19, Provide Name and Address of the School they Attend

School Name

Address (City) (State) (Zip)

Full Time Student? ☐ Yes ☐ No | Last Semester Enrolled | No. of Semester Hours

Description of Injury or Illness | Date of Accident or Beginning of Illness

If Accident, Where and How it Occurred

Is There Any Other Party Who is or May Be Responsible for Causing or Contributing to the Patient's Illness or Injury? If So, Provide the Name and Address of the Responsible Party, their Insurance Company and Their Attorney

Responsible Party Name

Address (Apt No.) (City) (State) (Zip)

Responsible Party Insurance Company | Responsible Party Attorney

Was Illness or Injury Due in Any Way to the Patient's Occupation? ☐ Yes ☐ No | If Yes, Please Explain

What dates did the patient become disabled or unable to work? | Date Patient Returned From Work

From Through | ☐ Part Time ☐ Full Time

List the Name(s) and Address(es) of All Physicians Who Have Consulted or Treated the Patient For This or Any Similar Condition

Physician Name | Date First Consulted

Address (City) (State) (Zip)

Physician Name | Date First Consulted

Address (City) (State) (Zip)

Physician Name | Date First Consulted

Address (City) (State) (Zip)

Are You or Any Other Family Member Covered by Another Group Health or Dental Plan? ☐ Yes ☐ No ☐ Health ☐ Dental

If Yes, is Coverage Provided through an Employer Sponsored Health or Dental Maintenance Organization (HMO/DMO) Plan? ☐ Yes ☐ No

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4401 82nd Street, Suite 1200 • Lubbock, TX 79424 • Phone: 800-747-9446 • Fax: 806-783-9991 • Customer Service Email: cs.T8@90degreebenefits.com

Name of Other Carrier			
Address of Other Carrier	(City)	(State)	(Zip)
Effective Date of Other Coverage	Type of Coverage ☐ Self ☐ Two-Person ☐ Family		
Employer Name	Group Number		
Employer Address	(City)	(State)	(Zip)
Employee/Subscriber Name	Birthdate	☐ Male ☐ Female	
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent			
If Eligible, Is Person Enrolled In Federal Medicare Part A ☐ Yes ☐ No	If Yes, Effective Date of Part A Is		
Federal Medicare Part B ☐ Yes ☐ No	If Yes, Effective Date of Part B Is		

Claim Reimbursement Details				
Date of Service	Provider Name	Item Description/ CPT/ HCPC	Amount Paid	Comments

Healthcare plan fraud is a felony that can be prosecuted. Any employee who willfully and knowingly engages in an activity intended to defraud the company healthcare plan will face disciplinary action and possible prosecution. I agree that if 90 Degree Benefits, on behalf of the plan, erroneously pays any claims in good faith based on inaccurate or incomplete information provided in my group enrollment materials, claims form(s) or otherwise by myself, my spouse or dependents, I will reimburse the plan in full for any such payment of expenses, including any legal expenses incurred in the recovery of such erroneously paid claims. I hereby certify that the above information is correct. I hereby authorize any physician, hospital, pharmacy, insurance company, employer or other person or organization possessing medical information or information concerning employment of me or any dependent including my spouse (if applicable) to permit 90 Degree Benefits or its representative, including Equifax Services, to view, copy, be furnished copies and be given details of all such medical information. This authorization shall be your authority to release and to furnish 90 Degree Benefits or its representative, including Equifax Services, such information as they may request concerning compensation, job duties, hours spent per week at my employer's place of business or other insurance and information relevant to my lifestyle and habits. I agree that should I or any covered dependent sustain an injury or illness alleged to have resulted from the actions of a third party, that unless otherwise stipulated by the plan, I will repay to the plan out of any monetary recovery all amounts paid by the plan in connection with that injury or illness.

Signature of Employee ______________________________ Date ____________