EMI Health

852 East Arrowhead Lane • Murray, Utah 84107-5298 • 801-262-7475 • 800-662-5850 • www.emihealth.com/web/claim.aspx

Medical Claim Form

USE THIS FORM ONLY FOR SECONDARY COVERAGE WHEN BOTH PRIMARY AND SECONDARY COVERAGE IS PROVIDED UNDER PLANS ADMINISTERED BY EMI HEALTH.

A. EMPLOYEE INFORMATION

EMPLOYER				MEMBER ID NUMBER
LAST NAME	FIRST	INITIAL	EMPLOYEE DATE OF BIRTH	E-MAIL ADDRESS
ADDRESS/STREET NO.	CITY & STATE	ZIP CODE		HOME PHONE
				BUSINESS PHONE

B. PATIENT INFORMATION

NAME	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH

C. OTHER INSURANCE AND EMPLOYMENT INFORMATION

NAME OF OTHER INSURED	MEMBER ID NUMBER
NAME OF OTHER EMPLOYER	TELEPHONE NUMBER
COVERAGE EFFECTIVE DATE	COVERAGE TERMINATION DATE (IF APPLICABLE)

D. ACCIDENT/ILLNESS INFORMATION

ACCIDENT **If this claim is for an injury, complete this section.**	DESCRIBE THE INJURY:	
	DATE OF ACCIDENT	LOCATION
	WAS ACCIDENT RELATED TO EMPLOYMENT?	WAS ACCIDENT AUTO RELATED?
ILLNESS **If this claim is for an illness, complete this section.**	DESCRIBE THE ILLNESS (DIAGNOSIS):	

E. AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT

DO YOU WANT PAYMENT TO GO DIRECTLY TO THE PROVIDER (DOCTOR, LAB, HOSPITAL, ETC.)? **(IF A BOX IS NOT CHECKED, PAYMENT WILL BE SENT TO THE EMPLOYEE.)**

YES ◯ NO ◯

I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, or other provider of health care services to release all information with respect to myself or any of my dependents that may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____

Patient's or Authorized Representative's Signature Date

PROCEDURES FOR FILING A SECONDARY CLAIM

1. Complete all information requested on this form, paying special attention to the following items:
   - Section A refers to the employee of the plan sponsor for the secondary coverage.
   - Section C refers to the primary coverage.
   - Section E requires you to indicate if you want payment to go directly to the provider.
2. Attach your EMI Health Explanation of Benefits (EOB) from the primary coverage for this claim.
3. Scan and submit both the claim form and the EOB to EMI Health at www.emihealth.com/web/claim.aspx or mail to the address above.