Mail Claims to:
P.O. Box 3559
Englewood, CO 80155
Fax: (303) 749-1184

# CLAIM FORM

## Wyoming School Boards Association Insurance Trust

| Employee Name | Member ID Number | Name of School District | Group # 22204031 |
|---|---|---|---|
| | | | |

| Home Address | City, State, ZipCode |
|---|---|
| | |

| Employee Date of Birth: | Phone Number: Home: _____ Work: _____ |
|---|---|
| | |

| Patient Name (if other than employee): | Male ☐ Female ☐ | Relationship to Employee: | Patient Birth Date: |
|---|---|---|---|
| | | | |

**If Patient listed above is covered as a dependent child of Employee:**

**Is Patient Married?** ☐ **Yes** ☐ **No** **Is Patient Employed?** ☐ **Yes** ☐ **No** **If yes, name and address of employer:** _____

**Is Spouse Employed?** ☐ **Yes** ☐ **No** **If yes, name and address of employer:** _____

**Are you, the patient or spouse covered under any other group plan, health maintenance organization, government plan, or insurance policy which will also pay for any of the expenses of this claim?** ☐ **Yes** ☐ **No. If yes, indicate name, address and policy number:** _____

**A. Authorization to release information:**
I certify that this information is complete and accurate and authorize release of information necessary to process this claim. A photocopy of this authorization shall be as valid as the original.

**X** _____ _____
**Patient or Parent (if minor)** **Date**

**B. Please pay benefits directly to:**
☐ **Employee** ☐ **Provider**
I hereby authorize payment of benefits directly to any providers of services, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

**X** _____
**Covered Person** **Date**

**How to file a claim:**
1) Complete, date and sign the above noted claim form. If all questions are not answered, this may delay consideration of your claim.
2) Attach the completed itemized bill and for which you are filing a claim and mail to the above noted address.

**IMPORTANT:** Each bill must show (a) name of patient, (b) date and charge for each service rendered, (3) diagnosis for each service if applicable; and (d) the type of service.

**DO NOT PRESENT CANCELLED CHECKS AS PROOF OF CLAIM. THEY DO NOT CONTAIN COMPLETE INFORMATION.**