



Mail this form to:
 EBS-RMSCO, Inc.
 P.O. Box 4863
 Syracuse, NY 13221-4863

For information please call:
 1-800-803-5773 Toll Free
 (315) 671-9894 Local Calls

Group Medical Claim Form

Member Identification No.	Group #					
Patient Name (First, Middle, Last)	Relationship to Employee Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			Sex M <input type="checkbox"/> F <input type="checkbox"/>		Patient Birth Date MO / DAY / YEAR
Employee name (First, Middle, Last)	Employer Name and Address					
Employee Mailing Address						
City, State, Zip	Was condition related to? Employment <input type="checkbox"/> Yes <input type="checkbox"/> No Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is patient covered by another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of other plan: _____		Group No. _____		Name and address of carrier _____
Has bill been paid by you? <input type="checkbox"/> Yes <input type="checkbox"/> No		Symptoms of Diagnosis _____		Date and time symptoms started or accident occurred _____		

Before signing claim form, please read the following.

Failure to submit a claim form without the information listed below will result in the claim being returned to you.

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|---|--|
| <ol style="list-style-type: none"> 1. In order for this claim to be processed, an itemized bill must be attached and include: <ul style="list-style-type: none"> ◆ The provider's name and address (hospital, Dr's, lab, pharmacy, etc.) ◆ The date(s) of service. ◆ The patient's name. ◆ Charges listed for each service. ◆ The description of service. ◆ Prescription receipts must include the prescription number, physician and name. ◆ Diagnoses or symptoms. | <ol style="list-style-type: none"> 2. If another insurance carrier or medicare had made payment on this service, their explanation of benefits form must be attached. 3. Only one patient may be included on a claim form. 4. There is no limit to the amount of bills you may attach to the claim form. 5. It is recommended that you keep copies of information submitted to EBS Benefit Solutions for your records. |
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Signature of Contract Holder _____ Date _____

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.