Submit Claims via EMAIL or FAX To:

Insight Benefit Administrators LLC

Fax: (616) 588-7915 Email: RA_TPA@insightba.net Claims Phone: (877) 827-1414 or (616) 588-5340

PATIENT INFORMATION			
Patient Name	Gender ☐ Male ☐ Female	DOB	Relation to Employee ☐ Spouse ☐ Child ☐ Self ☐ Other
If full time Student School		City	
Is patient Employed? ☐ Yes ☐ No	Employer Name		

EMPLOYEE INFORMATION			
Name	Employee SSN#	DOB	Status ☐ Active ☐ Retired
Mailing Address			
City	State	Zip Code	

CLAIM INFORMATION		
Claims for: ☐ Accident ☐ Illness	Is Condition work related? ☐ Yes ☐ No	Will or has a third party liability claim been filed? ☐ Yes ☐ No
Describe illness or accident	If accident, when and where did it occur	
Does patient have other health coverage? ☐ Yes ☐ No	If yes what Type? ☐ Medicare ☐ No Fault Auto ☐ Medicaid ☐ HMO ☐ Group ☐ Other ____ ☐ Private	
If yes above give name, address of other plan insurance carrier, HMO, Etc.		Policy or Plan No.

I certify that the information set forth in this claim form and any attachments is complete and accurate to the best of my information and belief. I authorize all appropriate persons or institutions to release to or obtain from the Plan administrator any information to process this claim. I agree to reimburse the Plan for any benefits paid on my behalf in the event that I or my dependent receives any monies which reimburses me for such expenses in whole or in part.

Signature: **X** _____**Date:** _____

I authorize the benefit payment to be made directly to the Physician or Supplier.

Signature X _____**Date:** _____

PHYSICIAN OR SUPPLIER INFORMATION			
Is condition related to:	Patient's Employment ☐Yes ☐ No	An Accident ☐Yes ☐ No	If yes, Date
Diagnosis or Nature of illness or injury			Referring Physician
1. 2. 3.			

Date of Service	Place of Service	Fully describe procedures, medical, or suppliers furnished for each date given identify with procedure code	Diagnosis Code	Charges

Your patients Account No.	*Must be furnished under authority of law	Total Charge➔	Amt. paid
Signature of Physician or supplier **X** _____ **Date** _____	Your social security No. * Your Employer No. *	Balance Due Physician's or supplier's name, address, Zip Code & telephone No.	