



**UNIFIED GROUP  
SERVICES, INC.**

Toll Free (800)291-5837 or Local (765)608-6680  
 Provider Benefit FaxPro (888)239-2940  
 Internet Info: <https://www.UGSWEB.com>

# BENEFIT CLAIM FORM

PLEASE MAIL COMPLETED FORM TO:  
**UNIFIED GROUP SERVICES, INC**  
 P. O. BOX 10  
 Pendleton, IN 46064  
 Fax claim to: 765-608-6689

Employee Name: _____		S.S.# _____	
Address: _____	<input type="checkbox"/> Check Box If New Address	Group# _____	
Street _____	City _____	State _____	Zip _____
_____		_____	
Patient First Name, Initial, and Last Name		Date Of Birth	

**IN ADDITION TO THIS MEDICAL COVERAGE, IS PATIENT COVERED UNDER ANY OTHER MEDICAL INSURANCE?**     YES     NO

**IF YES, PLEASE PROVIDE:**

**NAME OF EMPLOYEE:** \_\_\_\_\_ ( \_\_\_\_\_ )  
Employee Date of Birth

**NAME OF EMPLOYER:** \_\_\_\_\_

**INSURANCE COMPANY NAME:** \_\_\_\_\_

**INSURANCE COMPANY ADDRESS:** \_\_\_\_\_

**POLICY NUMBER:** \_\_\_\_\_

<b>PROVIDER OF SERVICES:</b>	<b>Attach Itemized Provider Bills.</b>
Name In Full	Address and Phone No.
1 _____	_____
2 _____	_____
3 _____	_____

**IS ILLNESS OR INJURY DUE TO EMPLOYMENT?**     YES     NO

**IS THIS THE RESULT OF AN ACCIDENT?**     YES     NO

**IF YES, PLEASE COMPLETE THE ACCIDENT SECTION ON BACK OF FORM.**

**FOR PROMPT CLAIM PAYMENT, COMPLETE ALL SECTIONS OF THIS CLAIM FORM AND ATTACH THE ITEMIZED BILL(S) FROM YOUR PHYSICIAN. CLAIMS FOR PRESCRIPTIONS MUST INCLUDE AN ORIGINAL PHARMACY RECEIPT. FOR QUESTIONS, CONTACT UNIFIED GROUP SERVICES, INC. AT (800) 291 – 5837.**

PLEASE TURN OVER

**IF THESE CHARGES ARE THE RESULT OF AN ACCIDENT, PLEASE ANSWER THE FOLLOWING QUESTIONS:**

**DESCRIBE THE ACCIDENT**

**- HOW IT HAPPENED** \_\_\_\_\_

**- WHEN IT HAPPENED** \_\_\_\_\_

**- WHERE IT HAPPENED** \_\_\_\_\_

**- WAS THIS A MOTOR VEHICLE ACCIDENT?**                       YES               NO  
**IF YES, PLEASE ATTACH A COPY OF THE POLICE ACCIDENT REPORT.**

**- IS ANYONE ELSE RESPONSIBLE FOR THESE CHARGES?**               YES               NO  
**IF YES, WHO?** \_\_\_\_\_

**- WHAT ARE THE INJURIES?** \_\_\_\_\_

**EMPLOYEE CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION**

**I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HEREUNDER IS TRUE AND CORRECT AND THAT THE EXPENSE WERE INCURRED BY THE NAMED PATIENT AND AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, OR PROVIDER OF SERVICE TO RELEASE TO UNIFIED GROUP SERVICES, INC. PRIOR TO OR AFTER PAYMENT, ANY AND ALL INFORMATION RELATED TO THIS CLAIM.**

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_  
EMPLOYEE

**SIGNATURE:** \_\_\_\_\_  
PATIENT, IF SPOUSE

**AUTHORIZATION FOR PAYMENT:**

**I AUTHORIZE UNIFIED GROUP SERVICES, INC. TO PAY THE PROVIDER DIRECTLY FOR THE MEDICAL SERVICES RENDERED BY THE PROVIDER.**

**EMPLOYEE SIGNATURE:** \_\_\_\_\_