MEDICAL/VISION CLAIM FORM

Address: P.O. Box 6392, Grand Rapids, MI 49516-6392
Phone: (616) 464-6635
Fax: (616) 464-4458
E-mail: claimsubmit@asrhealthbenefits.com

Claim Filing Process:
1. The employee completes and signs this form.
2. The employee submits the completed/signed form via mail, fax, or e-mail.

NOTE: Failure to answer all questions may delay payment.

Employer's Name:			Group Number (refer to ASR ID card):			
Employee's Name:			Date of Birth:			
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Legally Separated		
Address:						
Are you currently working?	☐ Yes	☐ No	If No, Date Last Worked:			
Spouse's Name:			Spouse's Date of Birth:			
Is spouse employed?	☐ Yes	☐ No	Is spouse eligible for insurance through employer?	☐ Yes	☐ No	
Spouse's Employer's Name:			Spouse's Employer's Phone Number:			
Spouse's Employer's Address:						
Patient's Name:			Patient's Date of Birth:			
If patient is a dependent child, please answer the following:			If the dependent child is age 19 or older, please complete the following:			
Is the child in employee's custody?	☐ Yes	☐ No	Name of College:			
Is the child financially dependent on employee?	☐ Yes	☐ No	Enrollment Date:			
Are you eligible for a tax exemption?	☐ Yes	☐ No	Graduation Date:			
Claim is for which of the following?	☐ Accidental Injury		☐ Illness	☐ Annual/Routine Health Exam		
Date Illness Began:			Date of First Treatment:			
Nature of Illness for Which You are Being Treated:						
Is claim for an accident?	☐ Yes	☐ No	If Yes, Date of Accident:			
Where did it occur?			Is the accident work related?	☐ Yes	☐ No	
How did it occur?						
Are you or your dependents covered under another group insurance plan, HMO, or a governmental plan such as Medicare?				☐ Yes	☐ No	
If Yes, Group Name:			Name of Member Insured under Other Plan:			
Policy Number:			Status of Member:	☐ Active	☐ Retiree	☐ COBRA
Effective Date of Other Policy:			Termination Date of Other Policy:			
Name of Other Insurance Company:			Address:			

PAYMENTS AND REIMBURSEMENT

I understand that all medical benefits will be issued directly to the service provider unless written evidence/receipt is submitted to ASR showing that I paid the charges. I realize that I am financially responsible for the charges my Plan does not pay. I agree to reimburse the Plan for any overpayments in excess of what the Plan allows. I agree to advise the Plan of any claim against a third party to recover any damages arising out of the event causing the Plan's payment of benefits as soon as I am aware that I may recover damages from another party. If I fail to provide the Plan with written notice of a claim or compromise or settle a claim without prior written consent, the Plan shall deem that I have committed fraud or misrepresentation in a claim for benefits and shall have the right to terminate my participation in the Plan. I further agree to reimburse the Plan for all benefits paid to me or on my behalf if I recover any money for the same accident or illness for which benefits were paid. This agreement applies to all recoveries, including benefits paid or recovered under any state or federal worker's compensation statute, whether by redemption, voluntary payment, compromise, settlement, court order, or any other form.

CERTIFICATION

I certify that these statements and answers are true to the best of my knowledge and belief.

X Employee Signature **(DO NOT TYPE OR PRINT)**:	X Date: