AmeriBen
P.O. Box 7186
Boise, ID 83707
Phone (208) 344-7900
Toll Free (800) 786-7930
www.myameriben.com

AZ MT ARIZONA Metropolitan Trust

Medical Claim Form

Patient Information

1. **Patient's Name** (First, Middle Initial, Last)	2. **Patient's Date of Birth** ___/___/___	3. **Patient's Address** (Street, City, State, Zip Code)

4. **Patient's Gender**
☐ Male ☐ Female

6. **Patient's Relationship to Employee**
☐ Self ☐ Spouse ☐ Child ☐ Other _____

5. **Was condition related to:**
a. Patient's employment
☐ Yes ☐ No
If yes, have you filed for Workers' Compensation?
☐ Yes ☐ No
b. An auto accident
☐ Yes ☐ No
c. Other type of accident
☐ Yes ☐ No
If yes explain,
_____

7. **Nature of Injury** (Please provide details of the accident or injury [how, when, where]. Use the back of this page if additional room is needed.)

8. **If condition was related to an accident and a police report was filed, please attach that report to this form.**

9. **Where was the service to the patient rendered:**
☐ Physician Office ☐ Outpatient ☐ Inpatient ☐ Ambulance ☐ Medical Equipment Supplier ☐ Pharmacy
☐ Laboratory ☐ Other _____

10. **Bills must be itemized.**
Each itemized bill must include:
☐ Name and address of provider ☐ Amount charged for each service ☐ Name of patient ☐ Diagnosis code ☐ Tax ID
☐ Service Provided ☐ Procedure code ☐ Date of service

Date of Service	Diagnosis Code	Procedure Code	Tax ID	Amount

Subscriber or Policyholder Information

11. **Subscriber's Name (First, Middle Initial, Last)**	12. **Subscriber's ID Number**	13. **Subscriber's Address** (Street, City, State, Zip Code)
14. **Subscriber's Date of Birth** ___/___/___	15. **Subscriber's Group Number** AMT001	16. **Subscriber's Group Name** Arizona Metropolitan Trust

17. **Is there other Medical ☐ Coverage (other than listed above)?**
☐ No ☐ Yes (If yes, please provide the following information.)

Policyholder name:_____ **Policyholder ID Number:**_____ **Group Number:**_____

Effective date of policy: _____

Name and address of the insurance company:_____

_____

_____

Please sign here: _____ **Date:** ___/___/___

By signing above, I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse AmeriBen to the extent of any overpayment which is in excess of the amounts payable under the benefit plan administered by AmeriBen.

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law. Please follow the instructions on the back of this form to file this claim with AmeriBen.

Please follow the instructions on the back of this form to file this claim with AmeriBen.

Procedure for Filing a Claim:

1. Complete the Claim Form on the opposite side.

   - Use one Claim Form per family member submitting a claim.
   - Make sure you complete all questions.
   - It is important to know when, how, and where your accident, illness, or disability began especially if it is job related.
   - Questions regarding other coverage you or your dependents are eligible for must be answered.
   - Patient or parent (if patient is minor) must sign.

3. Attach all medical bills relating to claim.

   - Make sure all bills identify patient.
   - All bills should show date of treatment, type of service, and amount of charges.

4. Mail claims to:

AmeriBen
P.O. Box 7186
Boise, Idaho 83707
or
Submit claims online
at www.myameriben.com.