



**EMPLOYEE PAID EXPENSE HEALTH PLAN CLAIM FORM**  
**FOR MEDICAL AND PRESCRIPTION CLAIMS\***  
*(This form is NOT to be used for Flexible Spending Account Claims)*

EMPLOYER NAME: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_

IDENTIFICATION NUMBER: \_\_\_\_\_  
(From Benefit ID Card)

PATIENT'S NAME (If different from Employee): \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Is this claim the result of an accident?     Yes             No

If yes, please give a brief description:

\_\_\_\_\_  
\_\_\_\_\_

Are you or any of your dependents covered under another plan?     Yes             No

If yes, Name of Plan: \_\_\_\_\_

Please send all claims to:

**LIFETIME BENEFIT SOLUTIONS**  
**ATTN: Group Health Claims**  
**P.O. BOX 21951**  
**EAGAN, MN 55121**

**or FAX to ONE of the following (315) 448-9132; (877) 249-5255; (888) 379-6245**

Check One:             Pay Employee             Pay Provider

**MAKE SURE ALL ENCLOSED BILLS LIST**

- **Date(s) of Service**
- **Itemized Charges**
- **Diagnosis Code**
- **Name and Tax ID of the Provider Rendering Service**

**IF A PRESCRIPTION CLAIM - Include Pharmacy receipt with NDC Number**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

\*Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claiming containing any materially false information, or conceals to the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.