Lifetime
BENEFIT SOLUTIONS
formerly EBS-RMSCO, Inc.

HEALTH CLAIM FORM
(FOR MEDICAL, MENTAL HEALTH & SUBSTANCE ABUSE SERVICES)

EMPLOYER NAME :			
EMPLOYEE NAME :			**LIFETIME BENEFIT SOLUTIONS ID # OR SS #:**
LAST	FIRST	MI	*(ID # can be found on your ID card)*
PATIENT'S NAME (IF DIFFERENT FROM ABOVE) :			**PATIENT'S DATE OF BIRTH**
LAST	FIRST	MI	
IS THIS CLAIM THE RESULT OF AN ACCIDENT? ☐ Yes ☐ No			If "YES," please provide a description of the accident.
ACCIDENT DESCRIPTION:			
ARE YOU OR ANY OF YOUR DEPENDENTS COVERED UNDER ANOTHER PLAN? ☐ Yes ☐ No			If "YES," please provide the name of the Plan.
IF YES, NAME OF PLAN:			
REMIT PAYMENT TO: ☐ EMPLOYEE ☐ PROVIDER			

MAKE SURE ALL ENCLOSED BILLS LIST

- DATE(S) OF SERVICE
- ITEMIZED CHARGES ("BALANCE BILL" STATEMENTS CANNOT BE PROCESSED)
- DIAGNOSIS CODE
- NDC NUMBERS FOR EACH PRESCRIPTION (IF APPLICABLE)
- NAME AND TAX ID OF THE PROVIDER RENDERING SERVICE

EMPLOYEE SIGNATURE _____ DATE _____

Please print and return this form with documentation to the address displayed on the back of your benefit ID card for processing.