MEDICAL & DENTAL
CLAIM FORM

INSTRUCTIONS: **1. Fill out the form. Be sure to sign it.** **[] MEDICAL**
2. Enclose the claim information form and fully itemized bills. **[] DENTAL**

For medical or dental bills which you submit, please complete the questions and enclose your fully itemized bills for processing. To expedite your claims, please submit your bills as they are incurred. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

1. Employer's Name:____Group #:__________________________________

   Employee's Name:____

   Employee's Social Security #:___________________________Employee's Phone #:_____________

   Employee's Address:_________________________________City_______________ST_____Zip______

2. Patient's Name:_____________________Date of Birth:___________Relationship to Employee:________

3. Is claim due to injury? []Yes []No

   If yes, what happened?____

   When and where accident occurred?____

   Did injury occur in the course of employment? []Yes []No

4. Do you or any of your dependents have other insurance? []Yes []No

   If yes, name of person{s} insured:______________________________Date of Birth:_________________

   If yes, name of other insurance company:____

   Address of insurance company:____

5. Name of spouse's employer:____________________________________Policy #:____________________

   Address of spouse's employer:_____________________________________Phone #:________________

I AUTHORIZE any physician, medical practitioner, dentist, hospital, clinic, or medically related facility, consumer reporting agency, insurance or reinsuring company, or employer to give to TIM DAVIS & ASSOC., INC. or its legal representative, any information required by TIM DAVIS & ASSOC., INC. to process my claim. This authorization includes information about: {1} drugs; {2} alcoholism; {3} mental illness. I ALSO AUTHORIZE TIM DAVIS & ASSOC., INC. to release any information obtained to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this authorization. I AGREE that a photographic copy of this authorization shall be as valid as the original.

X Signature of patient:____Date:__________________

Patient's or Authorized Person's Signature

NOTICE: Medical and Dental benefits, if any, are paid directly to the provider (the Doctor, Hospital, Dentist) unless you request us to pay otherwise. ***Sign below if payment is to be made directly to the insured.***

X Signature of insured:____Date:__________________

KCT CLAIM **MAIL TO:** **EMPLOYEE BENEFITS ADMINISTRATORS (eba)**
P.O. Box 2525
Elizabethtown, KY 42702-2525