INSURANCE MANAGEMENT SERVICES
P.O. Box 15688 • Amarillo, TX 79105

CLAIM INFORMATION FORM

Claims Fax 806-373-6646; Phone 806-373-5944; Toll Free 800-687-5944

1. Employee's Name _____ Social Security # _____
   Address _____ E-mail address: _____
   Date of Birth _____ Phone # _____
   Employer Name _____ Group # _____
2. Patient's Name _____ Date of Birth _____ Relationship to Employee _____
3. Spouse's Name _____ Date of Birth _____ Social Security # _____
   Name of Spouse's Employer _____ Phone # _____
   Address of Spouse's Employer _____
4. Do you or any of your dependents have other medical insurance **(including Medicare)**? ☐ Yes ☐ No
   If yes, name of other insurance company _____ Policy # _____
   Address/Phone of insurance company _____
   If yes, name of policy holder _____
   If yes, dependents covered under policy _____
   If other insurance is Medicare, please provide a copy of your Medicare card.
5. If applicable, is claim due to an injury? ☐ Yes ☐ No
   If yes, what happened? _____
   When and where did accident occur? _____
   Did injury occur in the course of employment? ☐ Yes ☐ No

I AUTHORIZE any physician, dentist, medical practitioner, hospital, clinic, pharmacy, or any other provider of health care, any insurance company, government agency or consumer reporting agency to disclose to Insurance Management Services or my employer all information and records relating to a diagnosis, treatment, medical history, physical or mental condition and evaluation, or any other information relating to me or my dependent children. I understand that any information obtained will not be released to any person or organization except its reinsurers, other persons or other organizations performing business or legal services in connection with my coverage, or as may be required by law, or as I may further authorize. A photocopy of this authorization remains valid for the term of coverage. I have a right to receive a copy of this authorization upon request.

_____ _____ _____
Employee's Signature Patient's Signature Date

I hereby authorize payment directly to the following Provider(s) **X** _____
Signature

Provider(s) _____

REMARKS: _____

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