



GREEN TREE ADMINISTRATORS

P.O. Box 7306, Beaumont, TX 77726-7306 · (409) 832-2335

STATEMENT OF CLAIM

Instructions

- Participant must complete **PARTS A and B**
- Attach your doctor's completed standard attending physician's form.
- Attach bills for covered expenses to this form. Bills must show patient's name, date, type of service, and amount charged. Drug bills must also show prescription (Rx) numbers.

PART A - Participant Information

No status change

Group Number		Participant's Company Name			
1. Participant's name (first, middle, last)		2. SEX (F/M)	3. Birth date	4. Member ID:	
5. Home Address (Street, city, state, zip)			6. Home Telephone No. ()	7. Are you: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	

PART B - Patient Information and Authorization

8. Claim is for: <input type="checkbox"/> Self if "Self, skip to question 13" <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child		9. Patient's Name		Social Security Number	10. SEX (F / M)	11. Birth Date
12. Complete only for claims on dependent children, age 19 or older. Is child fully dependent on your for principal support and a full-time student? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME & ADDRESS OF SCHOOL ATTENDING.				13. Reason for claim <input type="checkbox"/> Illness <input type="checkbox"/> Accident <input type="checkbox"/> Routine		
14. If "Accident", please provide date, place, and how it happened in spaces below:				15. Was illness or accident work related?		
Date	Place	How did it happen?		<input type="checkbox"/> YES <input type="checkbox"/> NO		
16. Was the patient totally disabled? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes", give date.				17. Is your spouse employed? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes", complete question 18.		
18. Please provide the following information if your spouse is employed.						
Name of Spouse				Social Security Number		Birthday
Employer's Name				Employer's Phone Number		
Employer's Address (Street, city, state, zip)						
19. Are you, your spouse, or your dependents covered by any other group insurance, prepaid health plan, Medicare, or other governmental plans? YES <input type="checkbox"/> NO <input type="checkbox"/> If "Yes", complete question 20 & 21				20. Types of Coverage's with effective dates :		
21. Please provide the following information for family members covered by other group policy or plan. Names of all family members covered by other group policy or plan:				*** Note *** Please attach copy of Certificate of Creditable Coverage from other insurance carrier. & copy of ID Card with Eff. date		
Insured's Name			Group insurance company or plan's name			
Certificate Number	Policy Number	Group insurance company or plan's address (street, city, state, zip)				
21. To all physicians and other health professionals, and all hospitals and other health care institutions: You are authorized to provide GreenTree Administrators and any independent claim administrators and consulting health professionals and utilization review organizations wit whom GreenTree has contracted, information concerning health care, advice, treatment or supplies provided the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits. GreenTree may provide the employer named below with any benefit calculation used in payment of this for the purpose of reviewing the experience and operation of the policy or contract. This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a cop of this authorization upon request and agree that a photographic copy of this authorization is valid as the original.						
Date: _____			Patient's or Authorized Person's Signature: _____			
Date:	Participant's signature			Spouse's signature (for dependent claims only)		