

Member Submitted Claim Form



Mail to:
WELBORN HEALTH PLANS
101 S.E. Third Street
Evansville, IN 47708

Please complete a separate form for each patient

Your information

Patient's name:

Last

First

Account number:

Patient's address: Check if address is new

Street

City

State

Zip

Patient's birthday:

Month

Day

Year

Patient's gender: Male Female

Patient is: the employee your spouse your dependent

About the claim

Describe the illness, accident, or condition:

Accidents:

Were the services used
as the result of an accident?
 Yes No

If "Yes" was the accident:

an auto accident at work
 at home other _____

When did the accident happen? Month ____ Day ____ Year ____ Time ____ : ____ AM PM

Other Coverage: Does patient have other group health insurance? Yes No

If "Yes" and you have not previously answered the questions below, please complete. If you have already answered them, please ignore.

Policyholder's name: _____ Birthdate of Policyholder: ____/____/____

Name and address of the other insurance company: _____

Policy or certificate number: _____ Effective date of other insurance: ____/____/____

Payment information

Is any payment on this claim to go to whoever provided services to you? Yes No If so, who?
If you received services from a preferred provider, the provider will file your claim.

Name:

Address:

Please sign

Both parts of this section must be signed or we will not process the claim.

A person who knowingly, and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony.

I have furnished the information on this form so that Welborn Health Plans may consider this claim. By signing below, I certify that the information is correct and that the expenses were incurred by the patient named above.

If I have indicated that any payments on this claim are to be made to others, I authorize Welborn Health Plans to make those payments directly. If any money is paid on this claim in error, or not authorized by the insurance contract, I agree to return it to Welborn Health Plans.

Employee's signature

Date

Authorization to Release Information:

I authorize any insurance company, employer, organization, or provider of services to release any information related to this claim to Welborn Health Plans or its authorized contractor before or after payment.

Patient's signature (even if employee) or parent or guardian of minor

Date

***PLEASE ATTACH ALL RECEIPTS AND/OR DOCUMENTATION**