Prominence
Administrative Services

MEDICAL / DENTAL CLAIM FORM

Please complete this form and attach any itemized bill.
Mail to: Prominence Administrative Services
PO BOX 981732, El Paso, TX 79998-1732

PLEASE CHECK ONE:

☐ MEDICAL ☐ DENTAL ☐ VISION

PLEASE FILL OUT THE FOLLOWING INFORMATION

EMPLOYEE NAME	SOCIAL SECURITY #	EMPLOYEE BIRTHDATE	PHONE NO.

MAILING ADDRESS	CITY / STATE	ZIP

PATIENT NAME (IF OTHER THAN EMPLOYEE)	☐ MALE ☐ FEMALE	RELATIONSHIP TO EMPLOYEE	PATIENT BIRTHDATE	IS PATIENT MARRIED? ☐ YES ☐ NO

IS PATIENT FULL TIME STUDENT? ☐ YES ☐ NO	NAME & ADDRESS OF SCHOOL	DATE ACCIDENT OR SICKNESS BEGAN

IF INJURED, HOW AND WHERE DID THE ACCIDENT HAPPEN?	DID THE ACCIDENT HAPPEN AT WORK? ☐ YES ☐ NO	HAS A CLAIM BEEN FILED WITH WORKER'S COMP? ☐ YES ☐ NO

NATURE OF SICKNESS, INJURY OR DIAGNOSIS	PHYSICIAN'S NAME

NAME OF SPOUSE	BIRTHDATE	IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME & ADDRESS OF SPOUSE'S EMPLOYER

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP HEALTH PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR THE EXPENSES OF THIS CLAIM? ☐ YES ☐ NO IF YES, PLEASE COMPLETE THE SECTION BELOW

POLICY HOLDER: _____

NAME AND ADDRESS: _____

_____

SOCIAL SECURITY NO.:_____

POLICY NO.: _____

EFFECTIVE DATE: _____

PATIENT OR PARENT MUST SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify this information provided is correct and true to the best of my knowledge.

X _____
Covered Person Date

IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER(S)
I hereby authorize payment of benefits to any provider of services, otherwise payable to me for services, but not to exceed the reasonable and customary charges for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X _____
Covered Person Date

PATIENT CLAIM FILING INFORMATION (HOW TO FILE):
Be sure to ask your provider of care if he/she will file a claim with Prominence Administrative Services. Please submit statements only if the provider does not bill us directly.

To receive benefits for services by a provider who does not bill us directly, complete this Claim Form, attach itemized bills and a proof of payment (if applicable) and mail to:

Prominence Administrative Services
PO BOX 981732
El Paso, TX 79998-1732

Please keep a duplicate copy of your itemized bills and proof of payment as they will not be returned to you. This claim may be returned to you if all required information is not present.

REQUIRED INFORMATION FOR ITEMIZED BILLS:
Summarizing the services may help us better understand the attachments if they are not clear. The attached itemized bills must include the provider name, patient's name, date of service, detailed description of service, and amount charged for that service. These must be valid documents from the provider.

If you have questions or need assistance, contact Customer Service at 800-455-4236.