

# Simplified Benefits Administrators Claim Form



<input type="checkbox"/> <b>Medical</b>	<input type="checkbox"/> <b>Dental</b>	<input type="checkbox"/> <b>Vision</b>
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PLEASE COMPLETE FOR ALL MEMBER SUBMITTED CLAIMS.  
ATTACH RECEIPTS AND ITEMIZED BILLS\* TO THIS FORM.

## Employee Information: Complete in all cases

Last Name	First Name	M.I.	Enrollee Number	Group Number

Street Address	City	State	Zip Code

Employer	Date of Birth (MM/DD/YY)	Gender	Marital Status
		<input type="checkbox"/> Male <input type="checkbox"/> Female	

## Dependent Information: Complete if dependent is the patient.

Name	Date of Birth (MM/DD/YY)	Relationship	Gender
		<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other	<input type="checkbox"/> Male Female

## Is patient covered by another medical plan:

- ☐ Yes (If yes, attach a copy of the identification card)  
☐ No

Employee Name	Name of Plan	Date of Birth (MM/DD/YY)	ID Number	Relationship

I certify that all information above is true to the best of my knowledge. I authorize the release of any medical or other information necessary to process this claim.

### REQUIRED FOR ALL CLAIMS:

Employee Signature and Date: \_\_\_\_\_

Spouse Signature and Date: \_\_\_\_\_  
(if spouse is patient)

### AUTHORIZATION FOR DIRECT PAYMENT:

Sign **ONLY** if you want payment to go to the provider of service instead of coming directly to you.

Employee Signature and Date: \_\_\_\_\_

## Please submit claim and all documentation to:

**Simplified Benefits Administrators**

**PO Box 4718**

**Englewood, CO 80155**

**Fax: 801.442.0041**

**Email: [customerservice@simplifiedbenefitsadministrators.org](mailto:customerservice@simplifiedbenefitsadministrators.org)**

\* Itemized bills must contain the following information: patient's name, date(s) of treatment, diagnosis, procedure code(s), location of service, fee for each service, provider name, provider address, provider tax identification number, provider NPI number.