

# WATERSTONE BENEFIT ADMINISTRATORS

## HEALTH BENEFITS SUBMISSION FORM

*In response to many requests, we have designed this Transmittal form for your use. If the questions listed below are answered completely it will eliminate most letters that are sent requesting additional information. This will allow us to be able to process your benefits in a timely manner.*

**Instructions:**

1. Attach bills for covered expenses to this form. Bills must show: Patient's Name, Date of Service, Type of Service, Diagnosis, and Amount Charged.
2. A separate claim form must be completed for each dependent, and those bills attached.
3. Return all claim forms and bills to:
 

Waterstone Benefit Administrators  
 4013 N.W. Expressway, Suite 575  
 Oklahoma City, OK 73116  
 (405) 440-8888 or (888) 440-0971

<b>Part A: Employee Information</b>				
1. Employee Name (Last, First, Middle Initial)	2. Insured ID Number			
3. Home Address (Street, City, State, Zip)				Married <input type="checkbox"/> Yes <input type="checkbox"/> No
Group Plan Number ????	Employer Name <b>COMPANY NAME</b>	Phone # Business _____ Residence _____		
Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse's Name _____	Spouse's Employer Name: _____ Address: _____		Phone No.: _____ Date Employed: _____ Spouse's Birth date: _____	
<b>Very Important</b>				
<b>Part B: Patient Information</b>				
Patient's Name		Birth date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Patient's Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Spouse            Explain: _____ <input type="checkbox"/> Child <input type="checkbox"/> Step Child		Does Patient reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		If answer to 14 is No, provide: Address: _____ _____ Guardian's Name (if patient is child): _____
Reason for Claim: <input type="checkbox"/> Illness <input type="checkbox"/> Accident Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No Auto Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Accident, please complete. (Additional space is available on the back of this form.) Briefly explain how it happened: _____ _____ Date: _____    Place: _____		
If patient is a child, is he/she:				
Employed Full-Time <input type="checkbox"/> Yes <input type="checkbox"/> No	Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	School Name and Address:	If Full-Time Student and over age 19, Furnish proof of Status.
Does Claimant have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No What type? <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Medicare <input type="checkbox"/> Other		Insured's Name: _____ Policy Number: _____	Other Insurance Carrier: Name: _____ Address: _____ Phone #: _____	Is Claimant Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No Last date at work _____ Dates Disabled: From: _____ To: _____
<b>Part C: Authorization</b>				
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 the third party administrators, 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 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 the coverage. I have a right to receive a copy of this authorization upon request.				
_____ Employee's Signature		_____ Spouse's Signature (If Spouse Claim)		_____ Date
Payment to be made to Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No				