MEDICAL CLAIM FORM

Mail to:
Luminare Health
P.O.Box 2905
Clinton, IA 52733-2905

Fax to: 913.387.5952

EMPLOYEE INFORMATION

Name (First, MI, Last)	Sex ☐ Male ☐ Female	Birthdate	Social Security Number

Home Address	City	State	Zip

Employer:	Date of Hire	Occupation	Date Last Worked

PATIENT INFORMATION

Patient Name (First, Middle, Last)	Relationship	Sex ☐ Male ☐ Female	Birthdate

Is the Patient Married? ☐ Yes ☐ No	
Nature of Illness	Name, Address and Phone No. of Doctor Seen For This Illness

IF CLAIM IS BASED ON AN ACCIDENT, COMPLETE THE FOLLOWING

Date and Time of Accident	Was Accident Work Related? ☐ Yes ☐ No	Place	How It Happened

SPOUSE INFORMATION

Name (First, MI, Last)	Sex ☐ Male ☐ Female	Birthdate	Soc. Sec. No.

Spouse's Employer Name	Address	Phone No.

OTHER INSURANCE INFORMATION

Do You or Your Dependents Have Other Coverage? ☐ Yes ☐ No	Type of Coverage? ☐ Single ☐ Family	Type of Plan? ☐ Group Health Plan ☐ Government Plan ☐ Medicare ☐ Other

Name of Person Covered by Other Insurance	Group Number	Soc. Sec. No.	Benefits ☐ Medical ☐ Dental ☐ Vision ☐ Other

Name and Address and Phone No. of Other Insurance Company

AUTHORIZATION TO RELEASE INFORMATION --
I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to Luminare Health for any oral or dental observation, treatment, services, or benefits rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

_____ _____
PATIENT'S SIGNATURE (*PARENT IF MINOR*) DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS --
I hereby authorize payment of benefits to any providers of service rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

_____ _____
PATIENT'S SIGNATURE (*PARENT IF MINOR*) DATE