



Employee Benefit Management Services, Inc. (EBMS) is a Third Party Administrator providing various services to employer sponsored group health plans.

EBMS received a claim(s) for medical expenses related to the date of service and medical provider listed below. On behalf of the group health plan, EBMS is trying to determine if this claim(s) resulted from an accident/incident (e.g. motor vehicle accident, accidental fall, incident at work, an assault, etc.). To ensure that your claim(s) is processed accurately and timely, EBMS needs your assistance.

Please respond to the following questions within ten (10) days.

Please explain the circumstances surrounding the injury or the onset of the illness: _____

Please indicate the date of the injury or the onset of the illness: Month_____ Day_____ Year_____

Please list all individuals that were with you during this time, or that may have caused or contributed to your condition/symptoms: _____

Is this claim(s) the result of an injury/accident/incident for which you **may** be eligible to receive compensation from another individual and/or entity? No_____ Yes_____

Was a police report filed? No_____ Yes_____ (If you answered yes, please attach a copy).

Where did the injury or the onset of the illness occur? _____

Did the injury or illness occur in the course of your employment? No_____ Yes_____

Have you filed a Worker's Compensation Claim? No_____ Yes_____

Please state the name of **your** insurance company(ies) (i.e. homeowners, automobile, other insurance) that may be responsible for *any* payment: _____

If applicable, you can either answer the following questions or attach photocopies of the relevant portions of your policy.

Carrier Address: _____

Policy & Claim Number: _____ Phone Number: _____

Policy Holder: _____ Policy Limits: _____

Does this policy have coverage for payment of medical expenses such as personal injury protection?

No_____ Yes_____

Did you receive any funds from this policy? No_____ Yes_____



Did this policy pay any medical providers? No_____ Yes_____ (If you answered yes, please attach a complete list of all claims paid by your insurance company or a letter from your insurance company stating their position on payment.)

Name of **other individual's and/or entity's** insurance company(ies) (i.e. homeowners, automobiles, other insurance) that may be responsible for any payment:_____

Carrier Address:_____

Policy & Claim Number:_____ Phone Number:_____

Policy Holder:_____

Did you receive any funds from this policy? No_____ Yes_____

Did this policy pay any medical providers? No_____ Yes_____ (If you answered yes, please attach a complete list of all claims paid by the insurance company or a letter from the insurance company stating their position on payment.)

Has a settlement been reached regarding this accident/incident? No_____ Yes_____

Amount of settlement_____ Date of settlement_____

Is there an Attorney representing the claimant/patient with respect to this accident/incident?

No_____ Yes_____

Name of Attorney:_____

Address:_____

Telephone Number:_____

I hereby authorize any medical provider, insurance carrier, employer, or organization to release to EBMS or its authorized agents on behalf of the group health plan, any and all protected health information, insurance coverage information, or employment-related information concerning any and all claims that pertain to this accident/incident for the purpose of validating and determining benefits payable in connection with this claim. I further authorize any insurance carrier, attorney, or other party in possession of any compensation and/or settlement proceeds to pay said funds directly to the group health plan, in care of EBMS, at the address below. If I am not the claimant/patient, I certify that I am legally authorized to sign this form on behalf of the claimant/patient. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby acknowledge that the group health plan contains a provision that requires me to reimburse the plan for any amounts it may pay on my behalf if another person or entity compensates me for this accident/incident, regardless of the amount of compensation received and regardless if my injuries are fully compensated. I have reviewed the Third Party Recovery Provisions of the group health plan and other related provisions and I agree to act in accordance with the provisions, including but not limited to my assignment of rights to the group health plan. With my assignment of these rights, I understand that the group health plan is asserting its equitable lien on any compensation I may be entitled to receive and is proceeding with payment of claims relating to this accident/incident due to the Plan's reliance upon my agreement to act in accordance with the applicable provision(s).

Employee Signature_____ Date_____



Claimant/Patient Signature _____ Date _____
(The signature of the Claimant/Patient is required if they are 18 years of age or older)

Upon receipt of the above-requested information, EBMS will process the claims(s) in accordance with the Plan. Please return all pages of this letter, completed, signed and dated, along with any applicable attachments, in the envelope provided.

If you have any questions or if we may be of further assistance, please do not hesitate to contact our offices at either (800) 777-3575 or (406) 245-3575.

Hispanos con preguntas por favor llamen al extension 517.

Sincerely,

Employee Benefit Management Services, Inc.
Claims Department

Patient:
ID#:
Date of Service:
Provider:
Group: