Limited Benefit Health Insurance Claim Form

Provider Bill Must Include Diagnosis

1. Employee Name (Last, First, MI)	2. Date of Birth	3. Address	4. Employer's Name

5. Member Phone #	7. Policy or Plan Number	9. Diagnosis for Treatment	10. Present Work Status Active Terminated Retired Leave of Absense COBRA	11. Date last actively at work:
6. SSN or Unique ID	8. Treatment Date of Service			

12. This claim is for (Check one box to identify the patient for the claim. If the patient is for your spouse or child, complete the information below.)				
Myself				
My Spouse	Name	Date of Birth	Male/Female	SSN:
My Child	Name	Date of Birth	Male/Female	SSN:

13. Is this claim for an accident? Yes/No If yes, complete 14	14. Date of Accident:	15. Was accident job related? Yes/No	Place of Accident: Home Work Other

☐ Accepts Assignment (payment will be sent to the provider)
☐ Does not accept assignment (payment will be sent to the employee)

The statements above are true and correct to the best of my belief. I authorize any hospital or physician to furnish TCC Benefits Administrator any information requested. Also, I hereby authorize my employer to release to or obtain from any organization or person or regulatory agency any information which may be necessary to determine benefits payable under the group policy. A photostatic copy of this authorization shall be considered as effective and valid as the original. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties.

____ _______________________________________

Employee Signature Date

TCC Benefits Administrator
PO Box 22557
Charleston, SC 29413
800-851-6268 Fax # 803-2649285

USE ONLY THIS CLAIM FORM
Crescent 9/12