Claim Assistance Form for Employee or Dependent

Doctors and Hospitals typically will only allow the patient or family member to review medical claim problems. This form will give us authorization to speak to the doctors and hospitals on your behalf, but only in reference to this particular claim in question.

I. Please send us the EXPLANATION OF BENEFITS (EOB) from your insurance company.

- This is the statement your insurance company sent denying their payment of this claim. We will need this to reference your claim.

II. Please send us the ITEMIZED BILL from the provider (doctor, hospital, or lab).

- Please check to insure the bill contains the following:
  1. Date of service
  2. Service(s) performed
  3. Provider name and Address
  4. Total dollar amount of each service

III. Please provide the reason(s) you or your family member sought treatment:

_____

_____

_____

_____ _____

Employee Signature **Date**

Please complete the following:

Company Name: _____

Employee Name: _____

Employee SSN#: _____-_____-_____ Employee date of birth: ___/___/_____

Employee Home Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone Number: ( ) _____ Home Phone Number: ( )_____

Insurance Company: _____ Group Number: _____

Patient's Name: _____ Patient's date of birth: ___/___/_____

Patient's SSN#_____-_____-_____ Relationship to Employee: _____

Date of Service: _____ Providers name: _____

Type of Service: _____ Charge: _____

If the Patient has Medicare: ☐ Part A effective date ___/___/___ ☐ Part B effective date ___/___/___

(For office use only: Amount pd _____ Ded _____Copay _____Member Liability _____)

Please fax or mail this form and the requested documents to:

DFBenefits
PO BOX 71027
Madison Heights, MI 48071

Phone: 1-248-336-0400
FAX: (248) 336-0399
www.DFBenefits.com