



INSTRUCTIONS FOR FILING A CLAIM

- 1. This form can be used for all medical, dental, vision and prescription claims.** The form only needs to be completed if the provider is not submitting the claim on your behalf. Out-of-Network claims can be submitted by the provider if the provider is willing and able to file on your behalf.
2. You must submit an itemized bill for your claim to be processed. Receipts, balance due statements and cancelled checks are not acceptable replacements for the itemized bill.
3. Itemized Bills Must Include:

Employee Name	Provider Name	Date of Service
Patient Name	Provider Address	Diagnosis Code
Type of Service (CPT Code)	Provider Tax ID Number	Charge for Service
4. If you received this claim form electronically, you may fill in the fields by clicking in the field and typing in the information.
5. If you are completing this form by hand, please use a new printed form rather than a photocopy to ensure the form can be scanned into our system. Also, please print clearly and use black ink when completing this form.
- 6. Claims must be received within the timely filing provisions of the plan for the claims to be considered payable. Please refer to your Plan Document for additional details on timely filing of claims.**
7. Use a separate claim form for each provider and for each member of the family. A new form may be obtained through your miBenefits account, at ebms.com or by calling a Client Services Representative using the toll-free number on your ID card.
8. To ensure the correct processing of your claim, please provide your ID Number. This can be found on the front of your ID card.
9. If your provider is contracted with your PPO, payment will be made to that provider even if you have submitted a receipt that shows you paid the charges in full (a zero balance).
10. If EBMS is the second payer for your services, you must submit the Explanation of Benefits (EOB) from the first insurance carrier for the services along with this completed claim form and the itemized bill.

EXPLANATION OF BENEFITS

You will receive an Explanation of Benefits (EOB) after your claim is processed which explains the charges applied to your deductible and any charges you may owe to the provider. Please keep these EOBs for later reference.

MAILING INSTRUCTIONS

If you are submitting claims by mail, please send to:
EBMS, Inc.
P.O. Box 21367
Billings, MT 59104-1367

If you have questions, please contact our Client Service Center at (800) 777-3575 or via our website: www.ebms.com

MEMBER CLAIM SUBMISSION FORM



P.O. Box 21367 Billings, MT 59104-1367
 Phone: 800.777.3575 or 406.245.3575 • Website: www.ebms.com

This form can be used for all medical, dental, vision and prescription claims.
 This form only needs to be used if the provider is **not** submitting a claim on your behalf.

Please refer to the previous page for instructions.

EMPLOYEE INFORMATION: To be completed by the Employee			
Employee Last Name:	First Name:	M.I.:	Date of Birth:
Current Mailing Address:			
Street	City	State	Zip
Member I.D. Number:	Phone Number:	Employer Name:	
PATIENT INFORMATION: To be completed only if the patient is other than Employee			
Patient Name: (First and Last)	Relationship to Employee: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
Patient Mailing Address: (If different than above)			
Street	City	State	Zip
At the time the medical service was provided, was the patient: <input type="checkbox"/> Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> N/A			
ACCIDENT/OCCUPATIONAL INJURY CLAIM INFORMATION: Complete only if the claim is a result of an accident or work-related injury			
Was the accident/injury due to Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was the injury due to an auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of injury:	
Brief Description of the accident or injury:			
Are you or your dependents filing a claim or lawsuit against a third party, including an insurance company, in order to recover the costs of expenses incurred as a result of this accident or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what is the name of the third party?			
FAMILY OR OTHER INSURANCE COVERAGE INFORMATION: Complete only if the claim is for a dependent and/or other coverage is in effect			
Is Spouse employed?: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, has spouse been employed during last 12 months? : <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Spouse:	Date of Birth:
Name and Address of Spouse's employer:			
Name	Street	City	State Zip
Is the patient covered under another group health plan or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please supply the following: Effective Date of Coverage: Policy Number: Type of Plan: (HMO, PPO, etc.)		
If there is other insurance and that insurance is primary, please enclose a copy of the explanation of benefits with this form and the itemized bill.			
CERTIFICATION:			
Any person who knowingly and with intent to defraud any employee benefit plan, 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 material fact thereto, commits a fraudulent act which is a crime. I certify that the information supplied is true and correct.			
Employee's Signature:			Date:
AUTHORIZATION TO RELEASE INFORMATION:			
I hereby authorize any provider, insurance company, employer or organization to release any information regarding medical, mental, dental, alcohol or drug history, treatment, or benefits payable, including disability or employment related information concerning this claim to EBMS or authorized agents for the purpose of validating and determining benefits payable in connection with this claim. A photo copy of this authorization shall be considered as effective and valid as the original. (The plan will not reimburse any provider charges for this release.)			
Employee's Signature:			Date:
<i>***Please be aware that if the provider of service holds a contract with your PPO network, payment will always be made to the provider even if this section is not signed. If the provider is contracted with the PPO, the provider will be paid at the contracted rate. (If you have already paid for these services, you should seek reimbursement directly from the provider.)</i>			