

MAIL CLAIM TO: TOPA BENEFITS PLAN
P. O. BOX 49699
LOS ANGELES, CA. 90049-0699
TELEPHONE: (888) 775-8672

CLAIM FORM - MEDICAL, PRESCRIPTIONS, DENTAL, VISION CARE

EMPLOYEE INFORMATION:

1. FIRST NAME _____ 2. LAST NAME _____ 3. DATE OF BIRTH: _____

4. SOCIAL SECURITY: _____ / _____ / _____ SEX: M - F

5. ADDRESS: _____ CITY: _____ ZIP CODE: _____

6. ARE OTHER FAMILY MEMBERS EMPLOYED? YES - NO

7. IF YES, GIVE NAME AND ADDRESS OF EMPLOYER _____

PATIENT INFORMATION:

1. FIRST NAME: _____ 2. LAST NAME: _____ 3. DATE OF BIRTH: _____

4. SOCIAL SECURITY NO: _____ / _____ / _____ SEX: M - F

5. DOES PATIENT HAVE OTHER HEALTH INSURANCE? GIVE NAME AND POLICY NUMBER BELOW: _____

6. IS PATIENT A FULL-TIME STUDENT? IF YES, PLEASE GIVE NAME OF INSTITUTION BELOW: _____

7. IS PATIENT CURRENTLY EMPLOYED? YES - NO

8. IF CLAIM IS RELATED TO AN ACCIDENT, DESCRIBE BELOW: _____

9. IS THE CLAIM RELATED TO THE PATIENT'S EMPLOYMENT? YES - NO

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

I AUTHORIZE THE PROVIDER OF SERVICE TO DISCLOSE MY MEDICAL RECORDS OR OTHER INFORMATION TO "TOPA BENEFITS PLAN" WHO WILL REVIEW MY BENEFIT REQUEST.

SIGNATURE OF EMPLOYEE/PATIENT: _____ DATE: _____

AUTHORIZATION OF PAYMENT:

I AUTHORIZE PAYMENT OF BENEFITS TO THE PROVIDER OR SUPPLIER OF SERVICES.

SIGNATURE OF EMPLOYEE/ PATIENT: _____ DATE: _____