MVP Select Care, Inc Claims Form

To Be Completed By Employee
Print out and return to address below

Information On Spouse And/Or Dependents Must Be Completed In Full Before a Claim Will Be Processed

#				
1	Employer's Name **MARIST COLLEGE**	Group#		
	Employee's Social Security No.			
2	Name of Employee	☐ Married ☐ Divorced ☐ Single ☐ Separated	☐ Male ☐ Female Birthdate	Telephone No. ( )
3	Address of Employee- Number and Street City State Zip Code			☐ Active ☐ Retired
4	Name of Patient Plan I.D.#		☐ Male ☐ Female Birthdate	Relationship
5	Employer (If any) Of Spouse or Dependent Child			
6	If Student, Name of School Presently Attending City State Zip Code Telephone No. ( )			
7	Is Patient Eligible For Medicare? ☐ Yes ☐ No	Is Patient Handicapped? ☐ Yes ☐ No	Is Patient Full-Time Student Over Age 18? ☐ Yes ☐ No	
8	Do You or Any of Your Family Members Have Any Other Health Insurance? ☐ Yes ☐ No	If Yes: (A)Insurance Co.________________________________ (B)Employer (Name and Address)_________________ (C)Policy or I.D. No.__________________________		
9	Nature of Illness			
10	Is Claim Based on Accident? ☐ Yes ☐ No / Did Accident Happen While Working? ☐ Yes ☐ No	Auto Accident? ☐ Yes ☐ No	Other ☐ Yes ☐ No	Date and Time of Accident
11	Description of Accident (How and Where)			

Authorization to Release: I hereby authorize MVP to release or obtain any information which may be necessary to be payable under this Group Plan.
Employee Signature____________________________________ Date Signed_______ ______________

Assignment: I hereby authorize payment directly to the hospital, physician or dentist herein named. I understand I am financially responsible for charges not covered by this assignment.
Employee Signature____________________________________ Date Signed_______ ______________

Assignment: I hereby authorize payment directly to employee named above. I understand I am financially responsible for charges not covered by this assignment.
Employee Signature____________________________________ Date Signed_______ ______________

Are Itemized Bills* Enclosed?

*An itemized bill is one that shows the patient's name, relationship, date of service, the type of service rendered and the nature of the condition being treated. If any information is missing, please write it on the bill yourself and sign your name.

FOR INFORMATION ON CLAIMS OR BENEFITS, CALL
Schendectady 518-370-4793 Toll Free Nationwide 1-800-229-5851

Is your form completed and enclosed along with your itemized bills?

MVP Select Care, Inc.
P.O. Box 1434
Schenectady, New York 12301-1434