



P.O. Box 99906  
Grapevine, Texas 76099  
FAX (469) 417-1960

# GROUP HEALTH CLAIM FORM

LSU First Health Plan

GROUP NUMBER LSUFIRST

Claim submitted with completed Group Health Claim Form is for:  Employee  Spouse  Dependent

**PLEASE COMPLETE FORM COMPLETELY. A GROUP HEALTH CLAIM FORM MUST BE COMPLETED FOR EACH CLAIM SUBMITTED. ATTACH ALL BILLS/CORRESPONDENCE IF YOUR PHYSICIAN IS NOT FILING THE CLAIM FOR YOU. IF CLAIM IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THE OTHER INFORMATION SECTION OF THIS FORM. ONCE YOU HAVE COMPLETED THE FORM, YOU MAY MAIL IT TO PO BOX 99906 GRAPEVINE, TX 76099, FAX IT TO 469-417-1960 ATTN: CLAIMS, OR EMAIL TO [LSUSERVICE@WEBTPA.COM](mailto:LSUSERVICE@WEBTPA.COM). CLAIMS MUST BE RECEIVED WITHIN 90 DAYS FROM THE DATE OF SERVICE.**

### **EMPLOYEE'S INFORMATION**

Employee Name _____	Date of Birth _____
Social Security Number _____	Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
Are you presently employed? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give name and address of employer
If not presently employed, please check which apply: <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	_____

### **SPOUSE'S INFORMATION**

Spouse Name _____	Date of Birth _____
Social Security Number _____	Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
Are you presently employed? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give name and address of employer
If not presently employed, please check which apply: <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	_____

### **DEPENDENT INFORMATION**

Dependent Name (First, Middle Initial, Last)	Social Security Number	Date of Birth	Gender (circle one)	Full-Time* Student (if over age 18)	Disabled**
			Male / Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\*\* Please provide updated disability information that was filed with Social Security.

### **ADDITIONAL INFORMATION**

Is the patient covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place, Date, and Description of Accident/Remarks: _____ _____ _____ _____ _____
If yes, complete the following information:	
Insured Name _____	
Insured Company Name _____	
Policy Number _____	
Policy Effective Date _____	

### **AUTHORIZATION FOR RELEASE OF INFORMATION**

**TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, CLINICS, PHARMACISTS, INSURANCE COMPANIES, EMPLOYERS, AND OTHER PERSONS OR INSTITUTIONS.** This authorizes you to give WebTPA, or its authorized representative who is employed to assist in the evaluation of my claim, any information, date or records you may have regarding me, my employment or my condition (including records pertaining to psychiatric, drug or alcohol use history, and any disability I may have had). I understand that any information obtained pursuant to this authorization will be used to evaluate my claim and may be transferred to an agency or person employed by WebTPA. I understand I have the right to request a copy of this authorization and that a copy will be sent to me if requested. A photocopy of this authorization may be accepted as effective and valid as the original. By signing, this form, I submit my annual information review and initial claim authorization. I understand that claims submitted under this authorization will be processed subject to continued proof of eligibility and all plan provisions. I verify that the information on the entire form is correct.

Patient/Authorized Person's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employee's Mailing Address \_\_\_\_\_  
Street City State Zip