

Purdue Health Plan EZ Claim Form

Important Information!

1. If all the information outlined below is already on your itemized medical bill, you may send the bill to Fiserv without this claim form.
2. You must submit a separate claim form for each bill to ensure the claim is paid correctly.
3. Remember to make copies of all documents for your own records.

Please complete the following information:

Employee Name: _____

ID Number (On Insurance Card): _____

Group Number (On Insurance Card): 76-190024

Patient Name: _____

Patient Date of Birth: _____

Relationship to Employee: _____

Is the patient covered by another group health/accident insurance policy (including Medicare)? ____yes or ____no

If yes, please provide the name of the Secondary Insurance Carrier:

Please pay benefit to ____YOU or ____PROVIDER

Employee Signature

Date

SUBMIT CLAIM TO: