BOON-CHAPMAN

CLAIM FORM

_____MEDICAL _____DENTAL _____VISION

Mail, Fax or Email Claims To:
Boon-Chapman
P.O. Box 1749
Rockwall, TX 75087
Fax: 972-772-6097
Email: rockwallvision@boonchapman.com

IMPORTANT: Itemized Bills for all covered expenses must accompany this Claim Form.

Employer: _____ Group # _____ Employee Id # _____

EMPLOYEE'S STATEMENT: TO BE COMPLETED BY THE EMPLOYEE

A: EMPLOYEE Name_____ Date of Birth_____
(Last) (First) (MI) Month-Day-Year

Address_____ ____Single ____Divorced
(Street) (City) (State) (Zip) ____Married ____Widowed

B: SPOUSE Name of Spouse_____ Date of Birth: _____
Is Spouse Employed? _____(Answer Yes or No)
If Yes: Employer_____ Phone # (____)____-_____

C: PATIENT __Myself ___Spouse ___Child (Name)_____ DOB_____
If Child: Is Child Employed? _____ Is Child Married? _____
Is Child a Full Time Student? _____
Name of Employer or School _____

D: THE CLAIM ___Injury Date_____ Where did it Happen?_____
_____Medical How did Accident Happen? _____
Was Accident Connected to Patient's Employment?_____(Yes or No)
___Illness When did Symptoms Begin? _____
When did you first see a Doctor? _____Doctors Name _____
Were you Hospital Confined? _____(Yes or No) Hospital Used_____

E: OTHER COVERAGE
Is Patient Covered by One of More of the Following, Including Any Carried by your Spouse:
A: Any other Medical or Dental Insurance or Plan? _____Yes _____No
If yes is this a Group or Individual Plan? _____
B: Any Federal, State, or Other Government Insurance Plan? _____Yes _____No
C: Any Medical or Dental Plan Sponsored by a School or College? _____ Yes_____No
IF ANSWER TO ANY OF THE ABOVE IS "YES" PLEASE ATTACH COPY OF PLAN ID CARD OR PLAN BOOKLET T OTHIS CLAIM FORM:

AUTHORIZATION*: I hereby authorize any licensed physician, medical practitioner, hospital, or other medical or medically related facility, insurance company, or other organization, institution, or persons that has any records or knowledge of me or of any member of my family, or my (our) health to release to Boon-Chapman any and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatments, and copies of all hospital or medical records. This authorization is valid from the date signed for the duration of the claim, unless revoked in writing by me or my legal representative. The information I have provided on this form is true and correct to the best of my knowledge. I agree that a photographic copy of this authorization shall be valid as the original.*

_____ _____
Signature of Participant *Date*