

Benicorp Insurance Company

Paid Claim Reimbursement Form



Member Information

Member ID #:		Phone #: ()	
Last Name:	First Name:	Middle Initial:	Date of Birth:
Street:			Apartment / Suite:
City:	State:	Zip:	New Address: <input type="checkbox"/> Yes <input type="checkbox"/> No

Patient Information

Last Name:	First Name:	Middle Initial:	Date of Birth:
Street:			Apartment / Suite:
City:	State:	Zip:	New Address: <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to Member:	Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	School Name:	

Claim Information

Have the providers listed below been paid for the claims indicated? Yes No

Be sure to attach proof of payment in the form of a copy of a cancelled check or a statement from the provider indicating that payment was received.

Date of Service	Provider	Billed Amount	Amount Paid
1.			
2.			
3.			
4.			
5.			

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE OR INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

Member Signature: _____

Date: _____

Send: *By Mail:*
 Benicorp Insurance Company
 P.O. Box 68917
 Indianapolis, IN 46268
 (800) 438-4002

By Fax:
 (317) 524-5219