Sharyland ISD

Medical Claim Form

Employee Name _____ **Member ID#** _____
Last First

Employee Address _____
Street Address City State Zip

How can we contact you? _____ _____
Daytime Phone Personal E-mail address (optional)

For prompt claim service please make sure to:

1) complete this form;
2) attach copies of itemized bills which indicate service date, provider, service, expense amount, family member, and diagnosis. Cancelled checks and credit card receipts alone are not sufficient.
3) Under "Plan" enter "A" for Alternate, "B" for Base, "H" for High, "S" for State
4) sign the Claim Form below.

Employee or Dep.	Date of Service	Provider	Plan	Type of Service	Amount requested
				Total Requested →	

Employee Certification:

I certify that the expense(s) listed above were incurred by me or my eligible dependent and qualify for reimbursement. All claims will be subject to all Plan provisions, limitations and exclusions AT THE TIME OF SERVICE. The patient must meet the Plan's eligibility requirements at the time of service.

Employee Signature _____ Date _____

Mail to: Frates Benefit Administrators
13439 Broadway Extension, Suite 110
Oklahoma City, OK 73114
(405) 290-5696

or

FAX to: (405) 775-5992
Attention: Health Claims

Contact us by phone (800) 850-7166

Frates
Benefit Administrators