



**SELF-FUNDED PLANS, INC.**  
 1432 Hamilton Avenue  
 Cleveland, Ohio 44114-1146  
 (216) 566-1455 or  
 1-800-722-7374

## SUPPLEMENTAL CLAIM FORM

### WHEN TO USE THIS FORM

You are required to complete one "Medical Claim Form" for the employee AND one "Medical Claim Form" for EACH dependent of the employee, EVERY calendar year.

After the required "Medical Claim Form" has been submitted on behalf of the employee or dependent for the current calendar year, subsequent medical claims can be filed using this "Supplemental Claim Form".

The "Supplemental Claim Form" **CANNOT** be used if: the claim being filed is the result of an accident or emergency illness and a description of the accident or emergency illness is required; there has been a change in employment of the employee's spouse; there has been a change in a dependent's status as a dependent; or there has been any other change which would affect the benefit.

Make sure to attach an itemized bill from your provider listing: the name of the patient; type of service rendered; date of service; amount of charge.

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

### DO NOT USE THIS FORM FOR SUBMISSION OF A NEW CLAIM

EMPLOYEE NAME	EMPLOYEE SOC. SEC. #	EMPLOYER	ACCOUNT NO.
DATE	CLAIMANT NAME	CLAIMANT RELATIONSHIP	REMARKS

IS PATIENT COVERED BY ANOTHER PLAN?     YES     NO

*(If "Yes", furnish name and address of employer, union, insurance company or governmental agency, type of coverage, and policy number below)*

I hereby certify that the above statements are true and accurate. I authorize any person or institution rendering care, or any person or organization in possession of information concerning insurance or other benefits covering me or my dependents, to furnish to, or receive from, SELF-FUNDED PLANS, INC. or its authorized representative (including my employer) full information regarding such care or other benefit information. A photocopy of this authorization shall be as valid as the original.

ATTACHED ARE ADDITIONAL MEDICAL EXPENSES IN CONNECTION WITH A CLAIM PREVIOUSLY SUBMITTED IN THE CURRENT CALENDAR YEAR.

**ASSIGNMENT:** I HEREBY AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO THE PHYSICIAN SIGNING THE MEDICAL CLAIM FORM.

EMPLOYEE SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_