MEMBER CLAIM

Fill out a separate form for each member submitting bills for covered services. MAIL COMPLETED FORM WITH BILLS AND PROOFS OF PAYMENT TO: BRMS, PO BOX 2140, FOLSOM, CA. 95763

PLEASE TYPE OR PRINT

SUBSCRIBER INFORMATION

SSN# OR MHB ® ID Number BE SUBSCRIBER SSN OF MHB ID MUST INDICATED TO ASSURE PROMPT PROCESSING OF THIS REQUEST	NAME: LAST FIRST			
ADDRESS	CITY	STATE	ZIP	TELEPHONE # ( )

PATIENT INFORMATION

NAME: LAST FIRST MI	BIRTH DATE (Mo/Day/Yr)	RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ DAUGHTER ☐ SPOUSE ☐ SON ☐ OTHER	BRMS GROUP #
BRMS MEDICAL GROUP NAME	WAS THE PATIENT OUT OF AREA FROM HIS / HER MEDICAL GROUP? ☐ YES ☐ NO	If YES, INDICATE REASON ☐ BUSINESS ☐ VACATION ☐ SCHOOL ☐ CHANGE OF ADDRESS ☐ OTHER _____	
MEDICAL EMERGENCY? ☐ YES ☐ NO	If YES, GIVE DATE OF EMERGENCY	IS THIS ILLNESS OR INJURY WORK RELATED? ☐ YES ☐ NO	If YES, INDICATE DATE OF INJURY (DATE) AND EMPLOYER NAME (NAME) _____

OTHER HEALTH INSURANCE

IS PATIENT PRESENTLY COVERED BY OTHER MEDICAL INSURANCE, INCLUDING MEDICARE? ☐ YES ☐ NO	If YES, PLEASE COMPLETE THIS SECTION		OTHER INSURANCE COMPANY NAME		
ADDRESS	CITY	STATE	ZIP	POLICY #	EFFECTIVE DATE
NAME OF INSURED POLICYHOLDER	BIRTH DATE (Mo/Day/Yr)		EMPLOYER NAME		
EMPLOYER ADDRESS			FOR MEDICARE, INDICATE PARTS MEMBER IS ENROLLED IN	PART A ☐ YES ☐ NO	PART B ☐ YES ☐ NO

Use this portion to report any accidental injury or emergency illness not treated by your BRMS medical group. Attach a bill or photocopy. Please be sure that duplicate bills are not submitted. If you are covered by another insurance carrier, please attach the Explanation of Benefits, which you can obtain from the other insurance carrier.

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Doctor, Lab, Ambul, Comp, RN, etc)	DESCRIPTION OF SERVICES RENDERED	ILLNESS OR DIAGNOSIS	TOTAL CHARGE	AMOUNT PAID BY YOU

NAME OF PERSON TO RECEIVE PAYMENT OR REIMBURSEMENT		RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ OTHER
NAME OF PERSON PREPARING FORM (PLEASE PRINT)	DATE	SUBSCRIBER SIGNATURE **X**