EGYPTIAN AREA SCHOOLS EMPLOYEE BENEFIT TRUST

ANNUAL BIOMETRIC SCREENING CLAIM FORM FOR EMPLOYEES ONLY WHEN USING AN OUT OF NETWORK PROVIDER.

As a benefit to covered employees, Egyptian Area Schools has implemented a Wellness Program. The first step of this program is to complete your biometrics screening. **You can use this form to file as a claim for reimbursement for out of network providers.**

EMPLOYER/GROUP NAME			EMPLOYER GROUP NUMBER (5 digit, found on ID Card)
EMPLOYEE NAME (Last Name, First Name, Middle Initial)	EMPLOYEE SOCIAL SECURITY NUMBER	EMPLOYEE BIRTH DATE MM DD YY	SEX M ☐ F ☐
EMPLOYEE ADDRESS (No., Street)			
CITY	STATE	ZIP CODE	TELEPHONE (Include Area Code) ( )

ASSIGNMENT: I hereby authorize payment directly to the hospital, physician, dentist or other health care provider herein named of the group benefits payable to me. I understand that I am financially responsible for charges not covered by this assignment.

SIGNED _____ DATE _____

DATE OF SERVICE	DIAGNOSIS CODE	PROCEDURES CODE	DESCRIPTION OF SERVICE	CHARGE
			Height	
			Weight	
			Blood Pressure	
			Total Cholesterol	
			HDL	
			LDL	
			Triglycerides	
			Glucose	

FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	PATIENT ACCOUNT NO.	ACCEPT ASSIGNMENT? YES ☐ NO ☐	TOTAL CHARGE	AMOUNT PAID

SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDINTIALS	PHYSICIAN INFORMATION
SIGNED DATE	NAME _____ ADDRESS _____ _____ STATE, ZIP CODE _____ PHONE #

For more information about Egyptian Area Schools Coordinated Health/Care contact your Care Coordinators at 1-855-452-9997.

Return completed form to:

Meritain Health
PO Box 2046
Fairview Heights, IL 62208

Or

Fax to: 888-525-2799