SYNERGY SUPPLEMENTAL EMPLOYEE BENEFITS

HEWITT COLEMAN

BSI COMPANIES

Medical Indemnity & Prescription Drug Claim Form

Please complete all sections of this Claim Form, SIGN, DATE then return by EMAIL, FAX or MAIL to the addresses noted below.
Submit only *ONE TREATMENT DATE PER CLAIM FORM*. Each additional Treatment Date should be on a separate form.
Up to THREE PRESCRIPTIONS may be submitted PER CLAIM FORM. Submit a separate form for more than three prescriptions.
Incomplete Claims Forms will be returned for completion, delaying the processing of your claim.
ATTACH: receipts, statements or other documentation to this form for prompt processing. THANK YOU

Employer Name	**Synergy Supplemental Limited Benefit Plan**	**Group #: 900**

EMPLOYEE INFORMATION

Employee Name:	**Date of Birth**: _____/_____/_____
Soc. Sec. No.:	**Phone #: ( )**
Address:	

PATIENT INFORMATION

Who is this claim for?

☐ **Myself**

☐ **My Spouse's Name:** Spouse **Date of Birth**: _____/_____/_____

☐ **My Child's Name:** Child **Date of Birth**: _____/_____/_____

ABOUT THE CLAIM

Is this claim due to an:

ACCIDENT: YES / NO	**Accident Date**: _____/_____/_____
What are your injuries? **How did the accident happen?**	
ON THE JOB INJURY: YES / NO	**Date of Injury**: _____/_____/_____
SICKNESS: YES / NO	**Illness Date**: _____/_____/_____

OUTPATIENT SERVICES

CHECK THE BOX for any OUTPATIENT services the patient received AND FILL IN THE DATE:			**Date of Service**
Physician Office Visit	Check Box		Fill in Date _____/_____/_____
Diagnostic Laboratory Procedures	Check Box		Fill in Date _____/_____/_____
X-Ray Procedures	Check Box		Fill in Date _____/_____/_____
Surgical/Anesthesiology Services	Check Box		Fill in Date _____/_____/_____
Anesthesiology	Check Box		Fill in Date _____/_____/_____
Emergency Room visit for illness	Check Box		Fill in Date _____/_____/_____
Emergency Room visit for accident or injury	Check Box		Fill in Date _____/_____/_____

INPATIENT HOSPITAL SERVICES

Was your hospital stay for Standard Care or Intensive-Critical Care?			**Admission Date**	**Discharge Date**
Standard Care	Check Box		Fill in Date _____/_____/_____	_____/_____/_____
Intensive Critical Care	Check Box		Fill in Date _____/_____/_____	_____/_____/_____

Did you receive Surgical and/or Anesthesia services?			**Date of Service**
Surgical Services	Check Box		Fill in Date _____/_____/_____
Anesthesiology	Check Box		Fill in Date _____/_____/_____

PRESCRIPTION MEDICATIONS

Prescriptions	**Prescription Number**	**Please indicate Generic OR Brand** **Generic**	**Brand**	**Drug Name**	**Date filled**
1					_____/_____/_____
2					_____/_____/_____
3					_____/_____/_____

CERTIFICATION & AUTHORIZATION (to be signed by the employee)

I hereby certify that the above answers and statements hereon and attached are to the best of my belief accurate. I hereby authorize any hospital, physician or other insurance company to furnish Hewitt, Coleman & Associates, Inc. or its representative or permit said company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records or other company records. A photocopy of this authorization shall be considered as valid as the original. I understand that this plan is a limited benefit indemnity plan and all payments will be made directly to me.

Employee Signature_____

Date _____/_____/_____

RETURN COMPLETED FORM TO:

Mail: P.O. Box 6708 Greenville, SC 29606
Telephone: 1-888-298-6828
Fax: 1-864-467-9489
Email: customerservice@bsicompanies.com
Website claim form:
www.hewittcoleman.com/synergy.htm

Submit ONE TREATMENT DATE Per Form
Up to THREE Prescriptions May Be Submitted per Form