CLAIM IDENTIFICATION FORM

Please use this form when submitting claims directly to:

110 S. Shipley Street
Seaford, DE 19973

Employer: _____ Plan #:_____

Employee: _____ Patient: _____

Address: _____

- IF YOU HAVE PAID THE PROVIDER – **do not sign this form** ~ submit unsigned.
- IF YOU **HAVE NOT** PAID THE PROVIDER ~ sign this form and submit.

EMPLOYEE'S SIGNATURE FOR ASSIGNMENT OF BENEFITS

I authorize and request payment of medical benefits to physician/provider for services listed on attached statements.

_____ _____

Signature *Date*