Member Form for Claim

Please use this form when submitting claims directly to

110 S. Shipley Street
Seaford, DE 19973

Cardholder Information	Group #
Name	Phone #
Address	

Patient Name

Claim Type
- ○ **Medical**
- ○ **Dental**
- ○ **Vision**

Select one:

- ○ I have paid the provider and request payment of benefits.
- ○ I **h**ave **not** paid the provider and I authorize and request payment of benefits to the physician/provider.

Signature _Date_