



Mail Claims to:
 NWS Claims
 PO Box 548
 Kalispell, MT 59903-0548

Medical Claim Form

Instructions

Use this form for medical expenses.

Submit a completed claim form with the first claim submission for the year for yourself and/or each covered dependent, using a separate claim for each patient.

Answer all questions below. Omitted information will cause delays in claim payment.

1. Employee Information

Name (print)	First	Middle	Last	Social Security Number -- --	Claim for Spouse	Self Dependent	Male Female
Address			City	State	Zip		
Employer				Employer Phone #	Date of Birth		

2. Patient Information

Name (print)				First	Middle	Last	Complete if claim is for dependent and/or if other coverage exists Are any benefits provided under another insurance plan or any prepayment plan (including Workers Comp and HMO), or pursuant to any law (Federal, State or Local) on account of the treatment reported on this claim? If YES, complete box 3. Yes No
Date of Birth	Relationship to Employee	Spouse	Child	Social Security Number -- --			

3. Other Coverage Information

Give name of other company providing benefits or services.		Please indicate ID number or group number
If patient is eligible for Medicare, attach a copy of the "Explanation of Benefits" from your Medicare Carrier.		Other Information

4. Accident Information

Complete this section if claim is a result of accidental injury or occupational illness (medical claims only)						
Is condition related to:	Employment	Yes	No	Accident	Yes	No
If accident motor vehicle?	Yes	No	Other accident	Yes	No	Explain:

5. Medical Authorization

MUST SIGN for all claims. Dependents over age 18 MUST also sign.	
I authorize any insurance company, organization, employer, hospital, physician, dentist, or pharmacist to release any information requested with regard to this claim and the expenses reported.	Signed (Employee) Date
I certify that the information I furnish in support of this claim is true and correct. I understand that it is unlawful to complete this form with facts that I know are false or left out that I know are important.	Signed (Dependent >18) Date

6. Assignment of Benefits

Complete ONLY if you want benefits to be sent DIRECTLY to the provider	
AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER OF SERVICES: I hereby authorize payment directly to the provider of service otherwise payable to me for his/her services but not to exceed the reasonable and customary charges for these services.	Signed (Employee) Date

7. Claim Information

Attach claim information from provider.	
The following information, at a minimum, is required on the physician billing statement.	ICD-9 Diagnosis or Nature of illness or injury
Provider Name (First and Last)	Date of Service
Facility Name and Address	Location Code
Provider Federal Tax ID Number	CPT's or HCPC's = Procedure, Services or Supplies
	Amount Billed and units if applicable