



MEDICAL CLAIM FORM

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • 1-800 752-5863
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sanfordhealthplan.com

Please print legibly and provide complete information. Attach an itemized bill and/or receipt for services(s).

EMPLOYEE INFORMATION

Employee Name: _____ Employee ID Number or SSN: _____

Employee Address, City, State, Zip: _____

PATIENT/MEMBER INFORMATION

Patient Name: _____ Birthdate: ____/____/____

Patient ID Number: _____

Are services for a work related injury? Yes No

Are services for a non-work related accident? Yes No

If yes to either of above, please supply details: _____

OTHER HEALTH INSURANCE INFORMATION

Does the patient have other health insurance coverage? Yes No

If yes, what is the name of the insurance carrier? _____

Insurance Carrier Address, City, State, Zip: _____

Subscriber's Name: _____ Policy #: _____

Phone #: _____ Type of Coverage: _____

PROVIDER INFORMATION

Provider of Services: _____

Provider Address, City, State, Zip: _____

Provider Phone #: _____ Date of Service: ____/____/____ Total Billed Amount: \$ _____

SIGNATURE

Employee Signature: _____ Date: _____