



**BMS**

Benefit Management Services

# BMS CLAIM FORM

fax your claim(s) to: 1-704-845-5629  
 Scan and E-mail to: claims@bmstpa.com  
 regular mail to: P.O. Box 1178 - Matthews, NC 28106

**INSTRUCTIONS:** Please type or print the required information. If the patient receiving the service is not you, please indicate the relationship (spouse or dependent child). Sign and return a copy of this form to **Benefit Management Services** via the fax number, E-mail address, or P.O. Box listed above. You may contact BMS at 1-800-228-1803 or info@bmstpa.com with any questions.

<b>Claim Type</b> (circle one):	Medical claim only	Dental claim only	Section 125 Flexible Spending Account claim	Medical / Dental claim <b>plus</b> Section 125
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## SECTION (I) PERSONAL INFORMATION

Employee Last Name	Employee First Name		Employee Middle Initial
Employee Social Security Number ____ - ____ - ____	Home Phone Number	Work Phone Number	E-mail address (if available)
Patient Name (write "self" if you)	Patient relationship to you	Patient Date of Birth	

## SECTION (II) ACCIDENT INFORMATION - Complete this section if this claim is due to ANY type of accident.

<b>Please read the question below and check yes or no in the box to the right</b>		YES	NO
Did this accidental injury result from an automobile accident or while inside a vehicle?			
Did this accidental injury occur while the patient was at work?			
Did this accidental injury occur while the patient was at school?			
<b>Please use the box below to describe the accident. Please include an additional sheet if required.</b>			
Location of accident (street address with city and state)			
If an auto accident, was there another vehicle involved? If so, please provide the following information about the other party: <b>name, address, phone number, other party's auto insurance information.</b>			

## SECTION (III) OTHER INSURANCE INFORMATION - Complete this section completely.

<b>Please read the question below and check yes or no in the box to the right</b>		YES	NO
Is the patient covered by any other group medical plan besides this Plan?			
Is the patient covered by any other private medical, dental, or accident insurance plan?			
Is the patient covered by any government sponsored medical plan such as Medicare or Medicaid?			
<b>If you answered yes, please furnish details about any other insurance in the box below.</b>			
Name of other insurance carrier:	Policy Number of other carrier:		
Effective Date of other insurance:	Other carrier's phone #:		
List all family members covered by this plan:			

## SECTION (IV) EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby certify that all information on this claim is accurate and that no information has been omitted.

Employee Signature	Date
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