



BCBA/HEALTHLINK
P.O. BOX 419104
St. Louis, MO 63141-9104

SUPPLEMENTAL CLAIM FORM

Please PRINT IN CAPITAL LETTERS with Black or Blue ink only -
• Send claims to address shown on Identification Card.

Employer Name _____ Group No. _____

Employee Name _____ Soc. Sec. No. _____

Home Address _____

Please check here if this is a change of address

Patient's Name _____

Relationship to Employee Self Spouse Unmarried Child

If claim is due to an accident, please give the following information:

Place _____ Date _____

Brief Description: _____

Is accident work-related? Yes No

Date Signed

Signature (Employee)

PLEASE NOTE: If this is the first claim submitted to The EPOCH Group for this family member within the last TWELVE MONTHS, then you MUST COMPLETE THE RED CLAIM FORM. A red claim form is also necessary in the event of an accidental injury or an inpatient hospital confinement. Subsequent claims can be submitted with this supplemental claim form, which is limited to very basic identification information.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to (PRINT - Name of Provider) _____ of the benefits otherwise payable to me. I understand I am financially responsible to the Provider for the charges not covered by this authorization.

SIGN HERE TO PAY PROVIDER DIRECTLY _____ DATE _____