EBMS for Wyoming Miner's Hospital Fund
Medical Claim Form

(For already registered members)
Updated 6-28-2012

Please help us to properly process your claim for benefits under your employer-sponsored health plan in conjunction with the Wyoming Miner's Hospital plan, by completing this claim form. **Remember medical benefits are payable if due to cardiac, respiratory, musculoskeletal and hearing conditions.** By filling out this form completely, you will help expedite the payment of your claim. Enclose all bills relating to this claim with patient's name, date of service and an itemization of charges, complete with diagnosis codes.

Name of Employee: ____Date of Birth: _________________________

Name of Employer: ____

Miner's ID: ____ Group: 0004443

Name and address of your primary insurance:

Company:____

Address: ____

Policy number:_____________________________

OTHER INSURANCE:

Do you have other health coverage: _______yes _______no

If yes, give the name of the company, address and policy number.

Company:____

Address: ____

Policy number:________________________

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any provider, insurance company, employer or organization to release any information regarding medical, mental, dental, alcohol or drug history, treatment, or benefits payable, including disability or employment related information concerning this claim to EBMS or authorized agents for the purpose of validating and determining benefits payable in connection with this claim. A photo copy of this authorization shall be considered as effective and valid as the original. (The plan will not reimburse any provider charges for this release.)

____Date: ______________________

Registered Miner Signature – I authorize payment of all benefits for services rendered by the provider to be sent to the provider.

____Date: ______________________

Registered Miner Signature – I certify that the foregoing information is true and correct.

Claims must be submitted by June 30th of the following year.

Any person who knowingly and with intent to defraud any employee benefit plan, insurance company, or other person files a statement contain any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act which is a crime.

Send this claim form and all documentation to:
EBMS, Inc.
P.O. Box 21367
Billings, MT 59104-1367
Toll Free (877) 240-2435
Fax (406) 652-5380