MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345
410-547-9111 * 800-811-MEBA (Toll-Free) * 410-659-1675 (Fax) * www.mebaplans.org

Statement of Claim for Members and Dependents

INSTRUCTIONS

- For **routine optical**, **orthodontia** or **hearing aid** benefits claimed, have attending physician complete the appropriate section on reverse side and/or attach itemized bills.
- For **prescription** expense balances only after primary insurance carrier payment, please attached itemized pharmacy receipts and other carrier payment information. Submit all other prescription expenses directly to the current prescription card company using their Direct Member Reimbursement Form which can be found on the MEBA website.
- A separate form should be submitted for each provider of service and/or patient.
- This form may be used to update any of the below information.
- Claimant's statement must be completed in full, signed and dated by member, spouse or responsible guardian.
- Benefits payable may be assigned providing proper authorization is completed on reverse side or submitted with statement. Checks will then be mailed directly to the provider of service indicated.

MEMBER INFORMATION

Member's Name (Last, First, Middle Initial) | **Date of Birth** | **ID#** XXX-XX-

Martial Status (Check One) Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐

Mailing Address Check box if NEW address [ ] | Street | City | State | Zip | Telephone Number ( )

Member Status (Check One)
Sailing [ ]
Port Engineer [ ]
Pensioner [ ] – complete patient info
Cobra [ ] – complete patient info
Other (Specify) [ ] _____

Last Employment: Company

Vessel

From Through

PATIENT INFORMATION

(Complete for DEPENDENTS, RETIREES and COBRA)

Patient's Name (Last, First, Middle Initial) | **Date of Birth** | **Gender** Male [ ] Female [ ]

Patient's Relationship to Member
Self [ ] Spouse [ ] Daughter [ ] Son [ ] Step- Daughter [ ]
Step- Son [ ] Parent [ ] Other [ ] _____

Is Patient Employed? Yes [ ] No [ ]

Name of Patient's Employer:

Patient Address (if different from above)
Street
City, State, Zip Telephone Number

If patient is other than your spouse, is your dependent:
Married? Yes [ ] No [ ]
Full-Time Student? Yes [ ] No [ ]

OTHER COVERAGE INFORMATION

Are you or your dependent(s) covered by any other insurance providing health care benefits?
Yes [ ] No [ ] If yes, please complete the following:

Name of Policyholder/Subscriber | **Relationship to Patient** | **ID Number** | **Group Number**

Is this coverage:
Group? [ ]
Individual? [ ]
Does this coverage included dependents? Yes [ ] No [ ]

Effective Date of Coverage: _____

Is coverage through:
Active Employment? [ ]
Retirement? [ ]

Employer Name: _____

Name of Other Insurance Plan:
_____

Does coverage include? Medical [ ] Prescriptions [ ] Vision [ ] Dental [ ]

Is Patient Eligible for Medicare?
Yes [ ] No [ ] If yes, please complete following
Medicare Eligible by virtue of : Age 65 and over [ ] End State Renal Disease [ ] Federal Social Security Disability [ ]
(copy of FSSD Award is required for our records)

Medicare Part A Effective Date : ____/____/_____ Medicare Part B Effective Date: ____/____/_____

"I hereby certify that all the above statements are true and complete according to the best of my knowledge and belief. I authorize any insurer, hospital, practitioner or other person(s) to disclose any information regarding my (or my dependent's) insurance coverage of medical history."

Date: _____ **Signature:** _____
(Adult Patient or Minor Patient's Parent/Guardian)

Patient's Name: _____ Patient's Date of Birth: _____

I hereby authorize payment of benefits directly to the provider of services indicated below:

Date: _____ Signature: _____

PLEASE HAVE PROVIDER COMPLETE BELOW OR ATTACH ITEMIZED BILL THAT INCLUDES ALL REQUIRED INFORMATION

OPTICAL BENEFIT

TO BE COMPLETED BY OPTHALMOLOGIST, OPTOMETRIST OR SUPPLIER

Eye Examination Prescription Lenses and Frames

Diagnosis (ICD-10): _____, _____, _____ Date of Exam: _____ Date of Purchase: _____

Services/Description	CPT/HCPCS Code	Charges		Services/Description	CPT/HCPCS Code	Charges
Exam				Lenses		
Determination of Refractive State				Frame		
Other:				Other:		
				Contact Lenses		
				Other:		

ORTHODONTIA BENEFIT

TO BE COMPLETED BY ORTHODONTIST OR DENTIST

Date appliance placed: _____ Total treatment fee: _____ Down payment fee: _____

Estimated months of treatment:_____ Total # of monthly payments:_____ Monthly maintenance fee:_____

Date of Service	Tooth Number	Procedure Code	Description	Charges

HEARING AID BENEFIT

TO BE COMPLETED BY PHYSICIAN, AUDIOLOGIST OR OTHER LICENSED PRACTITIONER

In my professional opinion a hearing aid is [ ], is not [ ] required.

Services/Description	Procedure Code (CPT/HCPCS)	Date of Service	Charges
Examination Fee			
Other:			
Hearing Instrument			
Other:			

PROVIDER OF SERVICE

I hereby certify that the services listed above are correct and represent those rendered to the patient named.

Physician/Practitioner's Name and Title (Print) Telephone No.

Street Address City State Zip Code

Date Physician/Practitioner's Signature Make check payable to:

Social Security Number **or** Employer Identification Number NPI Number License Number Provider Specialty Code

x x

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