SOUTHCOAST HEALTH SYSTEM
Health Plan

SUPPLEMENTAL CLAIM FORM

Instructions

Please complete items 1 through 6 below, and attach any receipts, bills or other documents that describe the services that you or your family member has received. Please make sure the attachment contains the provider(s) name and address, date(s) on which the service was performed, a description of the service, the charges, and the amount, if any, that you have already paid.

1. Employee Name: _____

2. Address: _____
   Street Address / PO Box

   _____
   Apt# / Suite

   _____
   City State ZIP

   _____
   Daytime Phone Number

3. Health Plans Member ID#: H H S H P ____ ____ ____ ____

4. Health Plans Group#: 0 0 1 S H P

5. Patient Name: _____

6. Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other

Assignment of Benefits

☐ I have paid this bill. Please reimburse me directly.

☐ I have not paid this bill. Please reimburse the provider of service.

Authorization

I hereby authorize payment of the group benefits payable to me directly or to the provider shown on the attached bill or receipt for the treatment or service described. I understand I may be financially responsible for charges not covered by this assignment.

I also confirm that none of the attached expenses were reimbursed under any other health coverage, including any flexible spending account, health savings account or health reimbursement arrangement.

_____ _____
Signature of Employee Date

Please submit the completed form, with copies of all related documentation and receipts, to:
Health Plans, Inc., P.O. Box 5199, Westborough, MA 01581

Health Plans, Inc.
1500 West Park Drive, Suite 330
Westborough, MA 01581

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fax: 508.754.9664
www.southcoasthealthplan.org

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