ebms
The Benefit of Balance

NAME:
ADDRESS:
MEMBER ID:
PLAN:
INJURED PARTY NAME:

Employee Benefit Management Services, Inc. (EBMS) is a Third Party Administrator providing various services to employer sponsored group health plans.

EBMS received a claim(s) for medical expenses that may be related to an accident. On behalf of the group health plan, EBMS is trying to determine if in fact this claim(s) resulted from an accident/incident (e.g. motor vehicle accident, accidental fall, incident at work, an assault, etc.) To ensure that your claim(s) is processed accurately and timely, EBMS needs your assistance.

Please respond to the following questions within ten (10) days.

Please explain the circumstances surrounding the injury or the onset of the illness:

Please indicate the date of the injury or the onset of the illness:

Month Day Year

At what location did the injury or the onset of the illness occur:

Please list all individuals that were with you during this time:

Please list all individuals that may have caused or contributed to the condition or symptom:

www.ebms.com

P.O. Box 21367
Billings, MT 59104-1367

P 406.245.3575
T 800.777.3575
F 406.652.5380

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Is this claim(s) the result of an injury/accident/incident for which you may be eligible to receive compensation from another individual and/or entity?

No ☐ Yes ☐

Did the injury or illness occur in the course of your employment?

No ☐ Yes ☐

Have you filed a Worker's Compensation Claim?

No ☐ Yes ☐

Claim #:

Please state the name of ***YOUR*** insurance company(ies) (i.e. automobile, homeowners, other insurance) that may be responsible for any payment.

Insurance Carrier Name:

If applicable, you can either answer the following questions or attach photocopies of the relevant portion of your policy:

Insurance Carrier Name:

Insurance Carrier Address:

Phone Number:

Policy Holder Name:

Policy Number: Claim Number:

Policy Limits:

Does this policy have coverage for payment of medical expenses such as personal injury protection or med-pay?

No ☐ Yes ☐

Did you receive any funds from this policy?

No ☐ Yes ☐

Did this policy pay any medical providers?

No ☐ Yes ☐

(If you answered yes, please attach a complete list of all claims paid by your insurance company or a letter from your insurance company stating their position on payment.)

Name of other ***individual's and/or entity's*** insurance company(ies) (i.e. automobile, homeowners, other insurance) that may be responsible for any payment:

Insurance Carrier Name:

Insurance Carrier Address:

Carrier Phone Number:

Policy Holder Name:

Policy & Claim Number:

Did you receive any funds from this policy?

No ☐ Yes ☐

Did this policy pay any medical providers?

No ☐ Yes ☐

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(If you answered yes, please attach a complete list of all claims paid by the insurance company or a letter from the insurance company stating their position on payment.)

Has a settlement been reached regarding this accident/incident?
No ☐ Yes ☐

Date of settlement: Amount of Settlement:

Is there an Attorney representing the claimant/patient with respect to this accident/incident?
No ☐ Yes ☐

Name of Attorney:
Address:
Telephone Number:

I hereby authorized any medical provider, insurance carrier, employer or organization to release to EBMS or its authorized agents on behalf of the group health plan, any and all information concerning any and all claims that pertain to this accident/incident for the purpose of validating and determining benefits payable in connection with this claim. I further authorize any insurance carrier, attorney or other party in possession of any compensation and/or settlement proceeds to pay said fund directly to the group health plan, in care of EBMS, at the address below. If I am not the claimant/patient, I certify that I am legally authorized to sign this form on behalf of the claimant/patient. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby acknowledge that the group health plan contains a provision that requires me to reimburse the plan for any amounts it may pay on my behalf if another person or entity compensates me for this accident/incident, regardless of the amount of compensation received and regardless if my injuries are fully compensated. I have reviewed the Third Party Recovery Provisions of the group health plan and other related provisions and I agree to act in accordance with the provisions, including but not limited to my assignment of rights to the group health plan. With my assignment of these rights, I understand that the group health plan is asserting its equitable lien on any compensation I may be entitled to receive and is upon my agreement to act in accordance with the applicable provisions(s).

Employee Signature Date
(The Signature of the Claimant/Patient is required if they are 18 years of age or older.)