BDG – Benefits Design Group
CLAIM FORM

Fax this form to: 972-596-9266 Or Mail this form to: P.O. Box 864109 Plano, TX 75086-4109	BDG Telephone Number 800-506-8307

Please fill out the following information:

Employer				
Employee Name			Patient	
Employee Address				
City	State	Zip	New Address? ☐ Yes ☐ No	Telephone
Email Address				

ASSIGNMENT OF BENEFITS

Who will the benefit be paid to? ☐ You ☐ Your Medical Care Provider
If you checked "Your Medical Care Provider", please complete the following:

Name of Provider to Receive Benefits			
Provider's Address			
City	State	Zip	Telephone

To all providers of health care: You are authorized to provide BDG Benefits Design Group, Inc. and any independent claim administrators and consulting health professionals and utilization review organizations with whom BDG Benefits Design Group has contracted, information concerning health care advice, treatment, or supplies provided the patient (including that relating to mental illness and/or AIDS/ARC/HIV). This information will be used to evaluate claims for benefits. This authorization is valid for the term of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this is as valid as the original.

Patient's or Authorized Person's Signature _____ **Date** _____

As the employee plan member, I certify that the above information is correct. I further certify that the attached EOB expenses constitute valid expenses incurred by me or my eligible dependents and none of the expenses have been reimbursed to me by any employer sponsored benefit plan.

Signed _____ **Date** _____

A copy of Insurance Carrier's Explanation of Benefits (EOB) must be submitted before any payments will be made.