UltraBenefits, Inc.

HRA CLAIM FORM

Group name:
TOWN OF WAKEFIELD
Effective date:

Administered By:
UltraBenefits, Inc.
Suite 110
22 Elm Street
Worcester, MA 01608

Website: www.ultrabenefits.com
Phone: (508) 438-0007
(866) UltraBenefits
Fax: (508) 438-2519

PLEASE PRINT CLEARLY

EMPLOYEE NAME	**Plan # H40**

EMPLOYEE ADDRESS (STREET, CITY, ST, ZIP)

IMPORTANT NOTICE	**TO AVOID DELAYS IN PROCESSING THE ATTACHED MEDICAL CLAIMS, PLEASE ENCLOSE ITEMIZED STATEMENTS WHICH INCLUDE DATE OF SERVICE, TYPE OF SERVICE, AMOUNT CHARGED, DIAGNOSIS AND PATIENT'S NAME ALONG WITH COPY OF EXPLANATION OF BENEFITS FROM YOUR HEALTH PLAN.**

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

By signing this form, I hereby authorize UltraBenefits, Inc. to make covered payments directly to the provider of services listed on the attached bill or to the member. If paid to the member, it is solely their responsibility to make any outstanding payments directly to the provider.

SIGNATURE OF EMPLOYEE	SIGNATURE OF PATIENT (if not Employee) or Parent, if minor	DATE

PROVIDER/SUPPLIER NAME	AMOUNT	PATIENT NAME	SERVICE DATE	PAY TO PROVIDER?
	$			☐ Y / N ☐
	$			☐ Y / N ☐
	$			☐ Y / N ☐
	$			☐ Y / N ☐
	$			☐ Y / N ☐
	$			☐ Y / N ☐
	$			☐ Y / N ☐
TOTAL	$			