

CLAIM IDENTIFICATION FORM

We can't process claims we can't identify. Please help us identify your claim faster by following the instructions below.

1. Complete this Claim Identification Form (Claim ID Forms may be photocopied).
2. Attach original bills (bills may NOT be photocopied).
3. Attach copy of "Certificate of Creditable Coverage" from your prior insurer with your 1st claim.
4. Mail to the address below. (Facsimile documents CANNOT be accepted.)

Please submit your claim within 90 days of the date of service.

Star HRG
 A Division of The MEGA Life and Health Insurance Company
 P.O. Box 55270
 Phoenix, AZ 85078-5270
 (800) 308-5948

Employee Name	Social Security Number
Home Address	Employee Birth Date
City & State	Zip
Name of Employer Company Name	0000
City & State	Has Employment Terminated? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Date
Patient Name (if other than Employee)	Male <input type="checkbox"/> Female <input type="checkbox"/>
Patient Relationship to Employee	Patient Birth Date
	Is Patient Married? Yes <input type="checkbox"/> No <input type="checkbox"/>

I authorize the release for the use by Star HRG and/or The MEGA Life and Health Insurance Company of any medical or other information needed in processing this claim. A photocopy of this authorization shall be valid as the original.

This authorization is valid for the term of the policy or contract under which a claim has been submitted.

Signed (Employee, All Claims) X _____ Date _____

Patient or Parent (if minor) X _____ Date _____

Any person who knowingly (with intent to injure, defraud, or deceive the insurance company) files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and maybe subject to fines and confinement in prison.

I certify that each of the statements made as part of this claim are complete and true to the best of my knowledge and belief.

Employee Signature _____
 SBCF0803 X

CLAIM IDENTIFICATION FORM

We can't process claims we can't identify. Please help us identify your claim faster by following the instructions below.

1. Complete this Claim Identification Form (Claim ID Forms may be photocopied).
2. Attach original bills (bills may NOT be photocopied).
3. Attach copy of "Certificate of Creditable Coverage" from your prior insurer with your 1st claim.
4. Mail to the address below. (Facsimile documents CANNOT be accepted.)

Please submit your claim within 90 days of the date of service.

Star HRG
 A Division of The MEGA Life and Health Insurance Company
 P.O. Box 55270
 Phoenix, AZ 85078-5270
 (800) 308-5948

Employee Name	Social Security Number
Home Address	Employee Birth Date
City & State	Zip
Name of Employer Company Name	0000
City & State	Has Employment Terminated? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Date
Patient Name (if other than Employee)	Male <input type="checkbox"/> Female <input type="checkbox"/>
Patient Relationship to Employee	Patient Birth Date
	Is Patient Married? Yes <input type="checkbox"/> No <input type="checkbox"/>

I authorize the release for the use by Star HRG and/or The MEGA Life and Health Insurance Company of any medical or other information needed in processing this claim. A photocopy of this authorization shall be valid as the original.

This authorization is valid for the term of the policy or contract under which a claim has been submitted.

Signed (Employee, All Claims) X _____ Date _____

Patient or Parent (if minor) X _____ Date _____

Any person who knowingly (with intent to injure, defraud, or deceive the insurance company) files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and maybe subject to fines and confinement in prison.

I certify that each of the statements made as part of this claim are complete and true to the best of my knowledge and belief.

Employee Signature _____
 SBCF0803 X

