Instructions for Claim Filing

Benefit Administrators

P O Box 14230

Springfield, MO 65814

1. Complete all appropriate boxes in the form below
2. Attach itemized bill which includes the following:
    - Patient's Name
    - Diagnosis Codes
    - Procedure Codes
    - Date of Service
    - Itemization of Charges
    - Receipt showing payment
3. Mail to Mercy Benefit Administrators

EMPLOYEE'S STATEMENT

<table>
<tr><td rowspan="4">FULLY COMPLETE FOR ALL CLAIMS</td><td colspan="2">Employee's Name (Please Print)</td><td>___Male
___Female</td><td>Employer</td><td colspan="3">Social Security Number or Member ID</td></tr>
<tr><td colspan="3">Address</td><td colspan="2">City</td><td>State</td><td>Zip Code</td></tr>
<tr><td colspan="2">Patient's Name (Please Print)</td><td>___Male
___Female</td><td>Patient's Date of Birth</td><td>Relationship to Employee</td><td colspan="2">Employee's Date of Birth</td></tr>
<tr><td colspan="7">Are any of these expenses for which this claim is being made covered by any other group coverage, Medicare, Medicaid, Veterans or union welfare plan? (Including any insurance or coverage carried by a dependent.) ___Yes ___No

If Yes, give the name and address of the insurance company and/or organization providing such benefits:
Name: ______________________________
Address: ______________________________
Phone Number: ____________________
Policy or Contract Number: ______________________________</td></tr>
<tr><td rowspan="2">COMPLETE FOR ALL INJURY OR ACCIDENT CLAIMS</td><td>Date of Injury</td><td colspan="3">Where did the injury occur?</td><td colspan="3">How did the injury occur?</td></tr>
<tr><td colspan="3">Is this a work related injury?
___Yes ___No</td><td colspan="4">Is this an automobile related injury?
___Yes ___No</td></tr>
<tr><td>SIGN HERE</td><td colspan="7">I HEREBY AGREE TO REIMBURSE MY EMPLOYER TO THE EXTENT OF ANY OVERPAYMENT, WHICH IS IN EXCESS OF THE AMOUNT PAYABLE UNDER THE PLAN. THE STATEMENTS ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY BELIEF. I AUTHORIZE ANY HOSPITAL OR PHYSICIAN TO FURNISH ANY INFORMATION REQUESTED TO FACILITATE REIMBURSEMENT. ALSO, I HEREBYAUTHORIZE MY EMPLOYER OR MERCY BENEFIT ADMINISTRATORS TO RELEASE OR OBTAIN, FROM ANY ORGANIZATION OR PERSON, ANY INFORMATION WICH MAY BE NECESSARY TO DETERMINE BENEFITS PAYABLE UNDER THE PLAN. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.
X____
EMPLOYEE'S SIGNATURE DATE PATIENT'S SIGNATURE (or legal guardian if patient is a minor)</td></tr>
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