EDISON EHS
HEALTH SOLUTIONS

QUICK CLAIM FORM INSTRUCTIONS

["Provider" includes any kind of Doctor's Office, Hospital, Clinic, Lab, etc.]

Please use this form (page 2) as a cover sheet to submit all reimbursement claims to EHS. If your physician does not bill insurance, please ask the physician for a superbill. That superbill should contain all of the information required below in order for EHS to process the claim on your behalf.

To avoid any possible delays, make sure to provide your Employee Contact Number on the form in case EHS needs to follow up with you for additional information.

Note: EHS cannot reimburse from a credit card receipt without the accompanying bill from the Provider.

Information Required for Reimbursement:

Provider Name
Provider Address
Provider Tax Id#
Diagnosis Code
Procedure or HCPC code
Total Billed Charges
Amount Paid by the Employee

EDISON EHS
HEALTHSOLUTIONS

P.O. BOX 4830 • Tulsa, OK 74159-0830
Toll Free 888-47EDISON (473-3476) • Fax 918-400-5003

Attn: Claims Office

Quick Submit

Employee Name		Employee Contact Number	
Street Address	City	State	Zip-Code
Employer		Group Number	
Patient Name	Date of Birth	Relationship of Patient ☐ Wife ☐ Son ☐ Stepchild ☐ Husband ☐ Daughter ☐ Self	
If Claim Is For a Dependent Child Age 19 or Older, Please Indicate →	Is Dependent a Full-time Student? ☐ Yes ☐ No	If Yes, Where?	

Is This Claim Due To An Accident? ☐ Yes ☐ No If Yes, Please Provide Details If No, Please Continue ↓	Accident Date	Was This A Motor Vehicle Accident? ☐ Yes ☐ No	Is This Accident Work Related? ☐ Yes ☐ No
	Please Explain Where The Accident Occurred		
	Please Explain How		

Is Your Spouse Employed? Yes ☐ No ☐	If Yes, Where?

Are You Or Your Dependents Entitled To Benefits Under Any Other Employer, Union, Student Assoc., Group Plan, HMO, Medicare, Medicaid, ETC.? ☐ Yes ☐ No	Name Of Other Plan	Plan Number

IMPORTANT NOTICE → TO AVOID DELAYS IN PROCESSING, PLEASE ENCLOSE THE ITEMIZED STATEMENT FROM THE MEDICAL PROVIDER WHICH INCLUDES DATE(S) OF SERVICE, TYPE(S) OF SERVICE, AMOUNT, DIAGNOSIS AND PATIENT'S NAME, & SOCIAL SECURITY NUMBER

TO ALL PHYSICIANS; MEDICAL PROFESSIONALS; HOSPITALS; CLINICS; OTHER HEALTH CARE PROVIDERS; INSURERS; EMPLOYERS; GROUP POLICYHOLDERS; INSURANCE SUPPORT ORGANIZATIONS; AND OTHER PERSONS WHO HAVE INFORMATION ABOUT THE PATIENT. I AUTHORIZE YOU TO GIVE ADMINONE, ITS REINSURERS OR ITS AGENTS; (A) ALL INFORMATION YOU HAVE AS TO ILLNESS, INJURY, MEDICAL HISTORY, DIAGNOSIS, TREATMENT AND PROGNOSIS WITH RESPECT TO ANY PHYSICAL OR MENTAL CONDITION OF THE PATIENT; (B) ALL EMPLOYMENT INFORMATION YOU HAVE ABOUT THE PATIENT; AND (C) ANY OTHER INFORMATION YOU HAVE ABOUT THE PATIENT WHICH ADMINONE, ITS REINSURERS OR ITS AGENTS; BELIEVES IT NEEDS TO PERFORM THE FUNCITONS DESCRIBED BELOW.THE INFORMATION OBTAINED WILL BE USED: (A) TO DETERMINE IF THE PATIENT IS ELIGIBLE FOR BENEFITS UNDER A CONTRACT INSURED OR ADMINISTERED BY ADMINONE, ITS REINSURERS OR ITS AGENTS, AND (B) FOR ANY OTHER PURPOSE WHICH RELATES TO THE CONTRACT. THIS FORM WILL BE VALID FOR AS LONG AS THE CLAIM LASTS. I KNOW THAT I MAY REQUEST A COPY OF IT. I AGREE THAT A COPY IS AS VALID AS THE ORIGINAL.

FRAUD STATE MENT → ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON 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.

Signature of Employee	Signature of Patient (If Not Employee) Or Parent, If Minor	Date
DO YOU WANT THE BENEFITS PAID DIRECTLY TO THE PROVIDER(S)? ☐ YES ☐ NO	Signature of Employee	Date