Municipality of Anchorage
Medical claims reimbursement form

Date of service (mm/dd/yyy) ____/____/________ Member ID no. ______________________

SECTION 1 | *Patient information*

Patient last name	First	M.I.	Gender ☐ Male ☐ Female
Date of birth (mm/dd/yyyy)	Social Security no.	Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	
Address	Street/P.O. Box	City	State / ZIP code
Home phone	Cell phone		
Group ID no.	Employer	Employer phone	

SECTION 2 | *Subscriber information*

Subscriber name	Social Security no.	Date of birth (mm/dd/yyyy)
Group no.	Policy no.	

SECTION 3 | *Secondary insurance* *(if applicable)*

Name of secondary insurance	Subscriber name
Group no.	Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

SECTION 4 | *Service information*

Name of provider		Place of service ☐ Clinic ☐ Hospital ☐ Other ________	
Phone	Fax	Date of service (mm/dd/yyyy)	
Procedure code	Diagnosis code	Is the condition due to an accident? ☐ Yes ☐ No	Will you file a claim against a third party for injury? ☐ Yes ☐ No

SECTION 5 | *Authorization*

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician or myself in the case that I have paid in full for the services. I understand I must complete the form in its entirety and provide the proper bills to process the claim. I also authorize the physician or insurance company to release any information required to process my claims.

Subscriber signature X	Date
Patient signature X	Date

PLEASE FAX OR EMAIL COMPLETED FORM AND LETTER OF REFERRAL TO:
ODS Healthcare Services at 855-522-9810 or email medical@odscompanies.com

If you have questions, please contact ODS Customer Service at 888-418-7543.

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