Integrity Administrators, Inc.

CLAIM FORM

Please complete this form and attach a copy of an itemized providers invoice/statement for reimbursement. The statement must reflect a zero "$0.00" balance owing for employee reimbursement, if a balance owed is showing, payment will be made to the provider.

Mail or fax completed form and provider statement to:
Integrity Administrators, Inc.
Attention: Claims
P.O. Box 13128
Sacramento, CA 95813-3128
Phone 1-800-562-9383
Fax (916) 921-3383 (attn: Claims)

Employee Name (First-MiddleInitial-Last):	Group Name: Lower Kuskokwim School District
Patient Name:	Group Number: 1180
Employee Number:	Employee Address:
Relationship of Patient to the Employee:	Type of Claim (i.e. Medical, Dental, Vision, Rx, etc.):
Total Amount of Claim: $	Total Paid by You: $
Does the patient have other insurance that may pay a portion of this claim? If so, please identify.	Were the services rendered due to an accident or on the job injury? If so, please explain.

Submission of this form does not guarantee reimbursement. Reimbursement will be provided according to your benefits and accumulation thereof.

The provider's statement/invoice must include procedure and diagnostic codes, along with amount billed for each procedure, patient name and provider tax identification number.

If you have any questions regarding how to complete this form, how/what to submit, benefits or eligibility, please contact Customer Service at 1-800-562-9383, Monday through Friday 7:30am-5:00pm Pacific Standard Time (PST).

Signature____________________ Date ____________