LOCKARD & WILLIAMS INSURANCE SERVICES

THIRD PARTY CLAIMS MANAGEMENT HEALTH BENEFIT CLAIM FORM

PLEASE COMPLETE PARTS 1, 2 AND 3 OF THIS FORM IN DETAIL

HOW TO FILE A CLAIM

- Complete your portion of this "Claim Form." Be sure to answer all questions to avoid delay in payment of benefits.
- Ask your doctor to complete the "Attending Physician's Statement" portion of this form.
- Attach itemized medical/surgical bill(s) not reported on the Attending Physician's statement.
- Each bill or statement must describe name of patient, nature of surgical or medical procedures and other services or supplies furnished as well as date and amount charged for each.
- If your group plan provides coverage for prescription drugs, submit itemized bills with this form.

WHERE TO FILE A CLAIM LOCKARD & WILLIAMS INSURANCE SERVICES
P.O. Box 1688 Pascagoula, Mississippi 39568-1688

PART 1 — EMPLOYEE INFORMATION

EMPLOYEE'S NAME	MALE/FEMALE	DATE OF BIRTH (MO, DAY, YR)	EMPLOYEE'S SOCIAL SECURITY NO./I.D. NO.
PAMELA J MILLER	F	2-15-1964	428-33-3571

EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP CODE	HOME TELEPHONE NUMBER
4500 SCARLET OAK DR	GAUTIER	MS	39553	228-497-6328

YOUR OCCUPATION	NAME OF FACILITY WHERE EMPLOYED	GROUP NUMBER
R N	Singing River Hospital	85445002

ARE YOU MARRIED?	NAME OF SPOUSE	DATE OF BIRTH (MO, DAY, YR)	NAME AND ADDRESS OF SPOUSE'S EMPLOYER
☑ YES ☐ NO	MARK PRIMO	3-3-1960	SELF EMPLOYED

ARE YOU, YOUR SPOUSE OR OTHER DEPENDENT(S) ENROLLED IN A HEALTH MAINTENANCE ORGANIZATION (HMO) OR COVERED UNDER ANY OTHER GROUP MEDICAL PLAN, OR ANY GROUP INSURANCE PLAN?		IF YES, GIVE NAME AND ADDRESS OF HMO FACILITY, EMPLOYER OR OTHER INSURANCE CO.
☐ YES	☑ NO	

PART 2 — DEPENDENT INFORMATION

IS CLAIM FOR A DEPENDENT	NAME OF DEPENDENT, IF OTHER THAN SPOUSE	DEPENDENT'S RELATIONSHIP TO EMPLOYEE
☑ YES ☐ NO	(SPOUSE) MARK PRIMO MILLER	SPOUSE

DEPENDENT'S DATE OF BIRTH (MO, DAY, YR)	IS THIS DEPENDENT MARRIED	IF DEPENDENT IS A FULL-TIME STUDENT, GIVE NAME AND ADDRESS OF SCHOOL
3-3-1960	☑ YES ☐ NO	

IS DEPENDENT EMPLOYED	IF YES, NAME AND ADDRESS OF EMPLOYER
☑ YES ☐ NO	SELF EMPLOYED

PART 3

IS THIS CLAIM DUE TO AN ACCIDENT	IF YES, DATE OF ACCIDENT	WAS A MOTOR VEHICLE INVOLVED	DID THIS ACCIDENT OCCUR WHILE WORKING FOR WAGE OR PROFIT
☑ YES ☐ NO	OCT 6, 2017	☐ YES ☑ NO	☐ YES ☑ NO

WHERE DID ACCIDENT HAPPEN	DESCRIBE HOW THE ACCIDENT HAPPENED
26139 Broad Ridge Dr, Picayune MS	DOG Broke Chain & BIT MY ANKLE

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above.

Authorization is hereby given to any hospital, physician, or other provider which participated in any way with the care and treatment or insurance company, prepaid health plan, employer or group policyholder, contractholder or benefit plan administrator to release to the above plan administrator any medical information and any employment information regarding the patient, which they in their judgment deem necessary to evaluate and administer claim benefits. This authorization is valid for the duration of the claim.

I know I have a right to receive a copy of this authorization and that its photographic copy is as valid as the original.

SIGNATURE (PATIENT, OR PARENT IF MINOR)	DATE
[signature]	12-1-2017

ADDRESS INQUIRIES TO:

LOCKARD & WILLIAMS INSURANCE SERVICES
P.O. Box 1688
Pascagoula, Mississippi 39568-1688
(228) 762-2500

SUBROGATION, RIGHT OF REIMBURSEMENT AND LIEN RIGHTS

I, the undersigned for myself and any covered dependents of mine, hereby acknowledge that to the extent of any payments made by the Health Plan for the benefit of the undersigned or covered dependent, the Health Plan is subrogated to my right to recover damages from another. The rights include the right of recovery from another, his insurer, or under any Uninsured Motorists, Underinsured Motorists, Medical Payments, No Fault, Personal Injury Protection (PIP) or similar coverage provisions. The Health Plan's rights shall be considered as the first priority claim against any source of recovery to be paid before any other claims which may exist are paid, including claims for general damages by any covered person. The proceeds of any said settlement of judgment shall be held as security for such right of reimbursement.

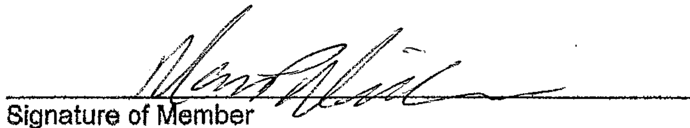
*The Health Plan does have a lien upon the proceeds of any said settlement or judgment resulting from the exercise of the right of recovery of the undersigned against the person or persons legally or financially responsible for personal or bodily injuries sustained for which the Health Plan has provided medical services. This lien shall apply against any accident related settlement even if the settlement does not specifically include payment for medical costs. I hereby assign to the Health Plan all monies received by settlement or judgment to the extent of the medical payment made by the Health Plan due to this accident.

*The undersigned must hold in trust and assign to the Health Plan any proceeds which the undersigned receives pursuant to any other medical care reimbursement coverage or benefit plan which proceeds are intended as payment for the same medical care, treatment, and services by the undersigned paid for or provided by the Health Plan.

*The undersigned shall do whatever is necessary and proper to secure the above rights of the Health Plan and shall do nothing to prejudice such rights. The undersigned must notify the Health Plan promptly as of how, when, and where an accident or incident resulting in personal injuries to the covered person occurred and all necessary information regarding persons involving insurance coverage. If any legal action or proceeding is commenced against any person or organization for the personal or bodily injuries or deaths sustained by the undersigned or covered person, the undersigned will promptly notify the Health Plan.

*Notice of the rights of the Health Plan including the above mentioned lien and reimbursement rights may be filed by the Health Plan with any person having a material interest in the existence of such rights, including but not limited to the Court in which any action is filed, the attorney for the undersigned, the person or organization legally responsible for said personal or bodily injuries, and/or any involved insurance carrier or medical provider.

*If, because of death, disability, minority, or any cause, the person signing this document is someone other than the member who received or is receiving the Health Plan benefits, the undersigned parent, guardian or other legal representative is authorized to execute this form.



Signature of Member

12-1-2017

Date

Receipt of this lien and assignment is hereby acknowledged and approved.

Signature of Attorney

Date

02/2001