

**REQUEST FOR EMPLOYER SUBSIDY CLAIM FORM**

Please mail or fax completed form to:

Ameraplan, Inc. • 3001 West Big Beaver, Suite 320 • Troy, MI 48084 • 248.643.9401 (fax)

**INSTRUCTIONS:**

- **Complete this entire form**
- **Attach itemized bill and/or receipt of payment**
- **Attach primary carrier voucher or Explanation of Benefits (EOB)**

**Failure to provide these items will result in a pended claim until missing items are received.**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------|
| <b>Employee Information</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |                |
| Company Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Employee Social Security # |                |
| Last Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | First Name                 | M.I.           |
| Streets Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Home Phone #               |                |
| City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | State                      | Zip            |
| <b>Dependent Information (Required when submitting claims for your dependents)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            |                |
| Last Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | First Name                 |                |
| Relationship to Employee (Circle One)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                |
| Spouse          Child          Full-time Student                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                |
| <p>I request and authorize you to furnish AmeraPlan, Inc. or its authorized representative, or to permit the representative to obtain a statement or review or make or obtain a copy, in whole or in part, of any or all information with respect to any illness or injury including but not limited to medical history, diagnosis, consultation, examination, prescriptions, treatments, operative procedures, X-rays, pathological findings or test you may have concerning me or my dependents. This information is to include alcohol abuse, substance abuse, or mental health records.</p> <p>A photocopy of this authorization shall be as valid as the original.</p> |                            |                |
| <p><b>Amount Requested:</b> \$ _____ <b>Service Rendered:</b> _____</p> <p><b>Make Check Payable To:</b>      <input type="checkbox"/> Provider                      <input type="checkbox"/> Employee (must provide proof of payment)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                            |                |
| Employee Signature                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            | Date Submitted |

~ [www.ameraplan.com](http://www.ameraplan.com) • Office 248.643.9400 • Fax 248.643.9401 ~

>>>Claims are available under the Claimant portal at [www.ameraplan.com](http://www.ameraplan.com)<<<