Subscriber Name ____ Date of Birth _______________

Group/Employer Name _______________________________ Insurance ID# __________________

Patient Name ____ Date of Birth ________________

Relationship of Patient to Subscriber: ☐ Self ☐ Spouse ☐ Child/Dependent

Is the documentation you are submitting for: ☐ Medical Insurance ☐ Flexible Spending Account

If the documentation is for Flex and you are submitting as a new claim, please complete the Flex Reimbursement form.

Is patient covered under any other health benefit plan? ☐ Yes (If Yes, complete the next section) ☐ No

Name of Insuring Company ____

Name of Policy Holder/Subscriber _____________________________ Date of Birth ______________

Relationship of Patient to Subscriber: ☐ Self ☐ Spouse ☐ Child/Dependent

______________________________________ ________________ _______________

Signature Date Phone Number

I certify the above is correct and complete and I understand that cases of fraud will be criminally prosecuted. I authorize the release of any information necessary to process this claim.

Submit form and any documentation to Amber (Medical) or Andrea (Flex) at EBS:
Amber: anupp@ebs-tpa.com (319) 758-8570 (Fax)
Andrea: flex@ebs-tpa.com (888) 511-3743 (Fax)