



Wellness Claim

To: Loyal American From: _____

Fax: 580-255-0951 Date: _____

Pages: _____ Phone: _____

INSTRUCTIONS

ATTACH A COPY OF THE DOCTOR'S BILL SHOWING THE SERVICE PERFORMED, DATE OF SERVICE AND CHARGE. FOR ASSISTANCE, CALL TOLL FREE 1-800-366-8354.

Policy Number _____ Name of Patient _____

Date of Birth _____ Male Female Student Where? _____

Name and Address of Primary Insured Patient is:

_____ Primary Insured

_____ Spouse

_____ Child

_____ Other _____