

# BenefitsDirect

Insurance Network

## Wellness Claim

To: Benefits Direct \_\_\_\_\_ From: \_\_\_\_\_

Fax: (816) 841-3790 \_\_\_\_\_ Date: \_\_\_\_\_

Pages: \_\_\_\_\_ Phone: \_\_\_\_\_

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### INSTRUCTIONS

**ATTACH A COPY OF THE DOCTOR'S BILL SHOWING THE SERVICE PERFORMED, DATE OF SERVICE AND CHARGE. FOR ASSISTANCE, CALL TOLL FREE 1-877-523-0176.**

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Policy Number \_\_\_\_\_ Name of Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male  Female  Student  Where? \_\_\_\_\_

Name and Address of Primary Insured \_\_\_\_\_ Social Security No. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient is:  Primary Insured  
 Spouse  
 Child  
 Other \_\_\_\_\_