MEMBER CLAIM FORM

Fill out a separate form for each member submitting claims for covered services.

EMPLOYEE INFORMATION

Employer: ______________________ SSN or ID #: ______________________

Name: ______________________ Date of Birth: ______________________

Address: ____

Phone Number(s) Mobile: ______________________ Other: ______________________

Email: ____

PATIENT INFORMATION

Patient Name: ______________________

Date of Birth: ______________________

Relation to Subscriber: ☐ Spouse ☐ Son ☐ Daughter ☐ Other

Is this request related to a work accident or injury? ☐ No ☐ Yes; Date of Injury: ______________

Is this claim related to a medical emergency? ☐ No ☐ Yes; Date of Emergency: ______________

CLAIM INFORMATION

Claim	Name of Member	Date(s) of Service	Description of Service(s)	Diagnosis/Illness (if applicable)	Total Charges	Amount(s) Paid by You
1						
2						
3						
4						
Total Claims Reimbursement						

OTHER HEALTH INSURANCE - POLICYHOLDER INFORMATION

This section only needs to be completed if the patient was/is covered by other insurance (including medicare) at the time of the claim.

Name of Policyholder: ____

Date of Birth: ______________________ If medicare, indicate enrollment: ☐ Part A ☐ Part B ☐ NA

Policyholder Employer: ____

Employer Address: ____

Other Medical Carrier: ______________________ Other Policy Number: ______________________

Relation to Subscriber: ☐ Self ☐ Spouse ☐ Other Form Prepared By: ______________________

FORM SUBMISSION

PHONE: (888) 326-2555

EMAIL: MemberClaims@brmsonline.com

SECURE FAX: (916) 467-1401

MAIL: BRMS-Claims
PO Box 2140
Folsom, CA 95763

Employee Signature: ______________________________ **Date**: ______________________