Submit Claims to:
EPSI TPA Austin Claims Operation
11910 Anderson Mill Rd. Suite 200
Austin, TX 78726
Fax: 512.222.1399 Ph: 855.495.1190

CLAIM INFORMATION FORM

Use this form for claims submitted by Member - Providers submit claims to address on ID card

EMPLOYER INFORMATION

Employer Name:	Group #:

EMPLOYEE INFORMATION

Employee's Name:	Member ID # (on your card):	Date of Birth:

Address:

Street:

City, State, Zip:

Phone Number:	Email Address:

PATIENT'S INFORMATION

Patient's Name:	Relationship to Employee:	Date of Birth:

AUTHORIZATION

I hereby authorize any physician, dentist, medical practitioner, hospital, clinic, pharmacy, or any other provider of health care, any insurance company, governmental agency or consumer reporting agency to disclose to Employer Plan Service (EPSI) or my employer all information and records relating to a diagnosis, treatment, medical history, physical or mental condition and evaluation, or any other information relating to me or my dependent children. I understand that any information obtained will not be released to any person or organization except its reinsurers, other persons or other organizations performing business or legal services in connection with my coverage, or as may be required by law, or as I may further authorize. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Employee Signature _____ *Patient's Signature (If other than member and over 18)* _____ *Date* _____

☐ ***I have paid this Provider in full, and request payment be made to:***

Name: _____

Address: _____

City, State Zip: _____

☐ ***I hereby authorize payment directly to the following Provider:***

Provider Name: _____

Address: _____

City, State Zip _____

_____
Signature

CLAIM INFORMATION

Please attach a detailed invoice to this claim form which contains:
Patient name, Provider, TIN #, Date of Service, Diagnosis and Service Provided (or Supply the Procedure Code)

Additional comments for the claims processor: _____