St. Petersburg College
CLAIM FORM (Physician)
Cancer/Dread Disease Medical Expense Reimbursement Plan (MERP)
January 1, 2021 through December 31, 2021

****Deadline for filing: Claims must be submitted within 180 days of the date the expense is incurred.*****

This form must be completed initially, and then, a new form must be completed every twelve (12) months.
If the instructions on the Claim Filing Process document are not followed correctly, your claim will be returned.

Please print your answers in black or blue ink.

Health Plan Member/Subscriber Information

(SPC employee/retiree carrying health insurance)

Name: ______________________________ Social Security Number: ________________

Daytime phone number: ____

Claimant/Patient Information

Name: ______________________________ Social Security Number: ________________

Date of birth ____/____/____ Relationship to health plan member/subscriber: ☐ self ☐ dependent ☐spouse

Mailing address: ____

____

Coverage Information

Check all that apply:

☐ I hereby certify that the claimant/patient named above is covered under SPC's health insurance plan.

☐ I hereby certify that the claimant/patient named above is qualified for, and covered by Medicare Parts A & B, if a Retiree.

The claimant/patient named above: does__________, does not___________, have supplemental health insurance.

If yes, please provide the following:

Name of insurance company providing supplemental insurance: ______________________

Name of health plan member/subscriber: ______________________________

Member number: ______________________Group ID number: ________________

Company phone number: ______________________________

Signature of Member/Subscriber: ______________________________

Rev: 04/24/2020

Authorization for Doctor's Release of Information

This form must be initially completed, and then a new form must be completed every twelve (12) months.

☐ I authorize the treating physician (or representative) to release the medical information requested on this form.

Signature of claimant/patient: ______________________________ Date: ____________________

Printed name of claimant/patient:____

Signature of Health Plan Member/Subscriber
(If claimant/patient is a minor or incapacitated):______________________________________

Physician Information

To be completed by the physician treating the cancer/dread disease.

Physician's name (please print clearly): ____

Address: ____

City, State, Zip: ____

Office phone number: _________________________Office fax number:_____________________

Diagnosis (please print clearly): ____

____

Date of initial diagnosis: ________________ Cancer/disease: is______, is not_, currently active as of the date the patient was last in my office (either today or the patient's most recent office visit).

Today's date: _________________________

Signature of physician: ____