St. Petersburg College
CLAIM FORM (Physician)
Cancer/Dread Disease Medical Expense Reimbursement Plan (MERP)
January 1, 2022 through December 31, 2022

*****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: _____

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: _____