Select Claim Type:
- ◯ Medical
- ◯ Dental
- ◯ Vision

Reimbursement Form

SECTION A: Employee Information

Employee Full Name: ______________________ Employee's ID: ______________________

Home Address: ______________________ E-Mail Address: ______________________

City: ____________ State: ______ Zip: ________ Employer Name: ______________________

☑ Check if new address Employer Group #: ______________________

I certify that all information provided is correct and that the claims submitted are for myself or members of my family who are eligible. The patient(s) listed below has (have) received the service, and I authorize release of all information contained on this claim to Paragon Benefits, Inc. and my Employer.

Employee's Signature: ______________________________ Date: ______________

SECTION B: Patient Information

Patient's Name (Last, First, MI)	Relationship to Employee	Gender	Itemized Medical Bills	Total $ Amount for Patient
	◯ Self ◯ Dependent ◯ Spouse ◯ Other			$
	◯ Self ◯ Dependent ◯ Spouse ◯ Other			$
	◯ Self ◯ Dependent ◯ Spouse ◯ Other			$
	◯ Self ◯ Dependent ◯ Spouse ◯ Other			$

TOTAL FOR ALL MEDICAL: ____________ $ ____________

SECTION C: Medical Claims

Provider Name/Address; Provider Tax ID Number; CPT Procedure Code; ICD Diagnosis Code; Date of Service; Charge Amount

Note: Altered receipts require signature.

SECTION D: Other Coverage Information (Specific coordination of benefits form available upon request.)

Is coverage for this claim provided by any other group insurance, federal program, or any other insurance program? ◯ Yes ◯ No

Name of other carrier: ______________________________

Policyholder's Name: ______________________________

Have these claims been processed by the other carrier? ◯ Yes ◯ No

SECTION E: Reason For Claim Submission or Special Notes:

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____

Mail the completed claim to:
Paragon Benefits
P.O. Box 12288 Columbus, GA 31917
Phone: 1.800.277.9218

Fax: 1.706.256.4089
Email: submitclaims@paragonbenefits.com