

Other Insurance Information:

Are you or any of your family members covered by another health plan? No Yes

If yes, please include subscriber name: _____

Name of other health plan: _____

For Pharmacy Charges:

Attach legible copies of receipts that include the following information:

Fill date, drug name, drug strength, quantity, days supply, prescription number, and your cost.

For Services Related to Certain Injury:

Were services related to a motor vehicle accident, a work/related injury, or any form of personal injury?

No Yes

Date of accident: _____

For Services Out of Country:

Services rendered at:

Office/Clinic Emergency Room Urgent Care

Pharmacy Inpatient/Outpatient Hospital

Country where treatment occurred: _____

Please explain injury or illness: _____

Submit all itemized receipts, proof of payment, and Explanation of Benefits along with the claim form to:

**Alliant, Options & Group Health Processing
P. O. Box 34585
Seattle, WA 98124-1585**

Questions?

If you have any questions, please contact Customer Service toll-free at 1-888-901-4636 (TTY Relay: 711 or 1-800-833-6388). You can also go to www.ghc.org, click on Customer Service, and send us an e-mail.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature: _____ **Date:** _____