E-Z CLAIM FORM
For Out-of-Network Claims Only

Name of Employer: The Loomis Company
Name of Employee: _____
Patient's Name: _____

Group Number:
Member Id Number: _____
Date of Birth: _____/_____/_____

Student Status:

Is dependent a full-time student? ☐ **Yes** ☐ **No**
If Yes, most current semester: _____
Please state school attending: _____

Accident Details:
If claim is for an accident, give complete details including date, how, when and where:
_____
_____
_____

Other Coverage:

Is patient covered by another group plan? ☐ **Yes** ☐ **No**
If Yes,
Name of Employer: _____ Group Number: _____
Insurance Carrier or TPA: _____

If Claim is to be paid to the Provider, the Employee's Signature is required:

_____ _____
Employees Signature *Date*

Complete this form and attach your itemized bill from your Provider.

In order to expedite processing, please review to make sure all the necessary information is presented on the statement(s) you are submitting:

- Health Care Providers: Type of treatment, diagnosis, date of service and charge.

Mail claims to: The Loomis Company, PO Box 7011, Wyomissing, PA 19610

Fax Number: 610-374-6986