S&S Healthcare Strategies
Claims Dept.
P. O. Box 46688
Cincinnati, OH 45246

S& HealthCare Strategies, Ltd.

PROCEDURES FOR FILING A CLAIM

1. Complete the "Employee, Part 1" section of the form. <u>Make sure you include your SSN and your employer or group name</u>
2. Attach your primary EOB and Claim Form (UB92 or HCFA 1500) to this form.

PART 1 MUST BE COMPLETED BY EMPLOYEE		
EMPLOYEE NAME	MEMBER NUMBER	NAME OF EMPLOYER
HOME ADDRESS	EMPLOYEE DATE OF BIRTH	GROUP NUMBER
CITY, STATE, & ZIP	HOME PHONE NUMBER	WORK PHONE NUMBER *(OPTIONAL)*
PATIENT NAME (____Female ____Male) (IF OTHER THAN EMPLOYEE)	RELATIONSHIP TO EMPLOYEE	PATIENT DATE OF BIRTH

ASSIGNMENTS OF BENEFITS
A SIGNATURE IS REQUIRED AS AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER(S)

I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

____ ______________________________

Signature of Covered Person Date

MAIL ALL CLAIMS TO S&S HEALTHCARE STRATEGIES P.O. BOX 46688, CINCINNATI, OH 45246

OR

FAX CLAIMS TO 513-772-9174

EQUIPOINT