ClaimLinx
10260 Alliance Road
Suite 325
Cincinnati, OH 45242
(513) 677-6262 or (800) 858-1772 Phone
(513) 677-6263 or (800) 858-1913 Fax
www.claimlinx.com

Dear Valued ClaimLinx Member:

You must complete these forms in order to complete the enrollment process of your secondary coverage.

1. **Provider Information Form** – this is so we may contact your provider and send them claim filing instructions.

2. **Protected Health Information Release Form** – this form authorizes ClaimLinx and other entities to discuss your medical coverage and claims on your behalf. Any member over 18 years of age must fill this form out.

Send all Forms to:

Email: enrollments@claimlinx.com

Fax: (513) 677-6263 or (800) 858-1913

Employer Name _____

ClaimLinx, Primary Carrier and Medical Cost Advocate Protected Health Information Release Form

I hereby authorize the disclosure of protected health information about me and/or my family as described below:

1) The following specific person or class of persons or facility is authorized to make the requested use or disclosure.

2) The following person or class of persons may receive disclosure of protected health information about me and/or my family:

Any employee or representative of
ClaimLinx, Primary Carrier, or
Medical Cost Advocate

3) The specific information that should be disclosed is: As requested

4) I understand that the information used or disclosed may be subject to re-disclosure by ClaimLinx, Primary Carrier, or Medical Cost Advocate or by the facility receiving it (i.e. hospitals, doctors, medical facility). In such cases, information will remain protected by federal privacy regulations governing the disclosure of protected health information by ClaimLinx, Primary Carrier, and Medical Cost Advocate.

5) I may revoke this authorization by notifying ClaimLinx, Primary Carrier, and Medical Cost Advocate in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider or insurance carrier to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6) This authorization expires upon occurrence of the following event that relates to me and/ or my family or to the purpose of the intended use or disclosure of information about me and/or my family: termination of relationship with ClaimLinx, Primary Carrier, and Medical Cost Advocate.

_____ _____
Signature of Individual or Guardian Date of Signature

_____
Printed Name of the Above Signed

_____ _____
Phone Number

_____ _____
Address Email Address

_____ _____
Date of Birth of the Above Signed Social Security Number

****SEND COMPLETED FORM TO CLAIMLINX****
EMAIL TO ENROLLMENTS@CLAIMLINX.COM OR FAX TO (800) 858-1913

Employer Name _____

Employee Name _____

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Primary Medical Provider Information Form

To smooth the transition of claims processing for your plan, ClaimLinx would like to contact your primary physician. This is the person you normally see for medical treatment.

Examples are: Family medicine, Internal Medicine, Pediatrician, OB/GYN, Group Practice Doctor, Allergist, etc.

Please list below any medical providers that fall into the listed categories.

1) Name _____ **Category** _____
(First Name, Last Name, Suffix)

Address _____

City/Sate/Zip _____

Phone _____ Fax _____

2) Name _____ **Category** _____
(First Name, Last Name, Suffix)

Address _____

City/Sate/Zip _____

Phone _____ Fax _____

3) Name _____ **Category** _____
(First Name, Last Name, Suffix)

Address _____

City/Sate/Zip _____

Phone _____ Fax _____

4) Name _____ **Category** _____
(First Name, Last Name, Suffix)

Address _____

City/Sate/Zip _____

Phone _____ Fax _____

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