ANNUAL PHYSICAL EXAMINATION BENEFIT – PLAN A PARTICIPANTS ONLY

EFFECTIVE DATE

JANUARY 1, 2019 – DECEMBER 31, 2019

CLAIM SUBMISSION FORM

*Encounter or Provider Claim form with *Date of Service* must be included with Claim Submission Form

THE ATTACHED BILL IS FOR MY ANNUAL EXAM.

PHYSICIAN/PROVIDER: ______________________________________

DATE OF SERVICE: ______________________________________

EMPLOYEE NAME (PRINTED): ______________________________________

LAST 4 DIGITS OF EE SSN: ______________________________________

EMPLOYEE PHONE # ______________________________________

EMPLOYEE SIGNATURE: ______________________________________

MAIL OR FAX TO:

1ST CHOICE WELLNESS COORDINATORS
4498 W. US HWY 90
LAKE CITY, FL 32055

FAX: (386) 755-7264

INTEROFFICE USE ONLY:

CLAIM RECEIVED DATE: ____

CLAIM APPROVED/DECLINED: ____

CLAIM REVIEWED BY: ____