



Patient Questionnaire / Claim Form

- This form is to be used in filing your provider's statement with Riverside Benefit Administrators, Inc. To use this form:
1. Complete the Patient and Subscriber Information section & Other Health coverage section;
 2. If the services were related to an accidental injury, you must also complete the Accident Injury Information section;
 3. Attach a copy of your medical provider's billing statement to this form. A provider's billing statement must include the date of service, a diagnostic code and a procedure code for each charged amount. *A separate Patient Questionnaire must be submitted for each patient.*
 4. Mail the completed Questionnaire/Claim Form to:

Riverside Benefit Administrators
 PO Box 5429
 Boise, ID 83705-0679
 5. You should receive an Explanation of Benefits in about three weeks or less. Please do not re-submit these charges in the meantime.

Patient and Subscriber Information		
Patient's Name: (First, Middle Initial, Last)	Patient's Date of Birth:	Patient's Gender: <input type="radio"/> Male <input type="radio"/> Female
Subscriber's Name (First, Middle Initial, Last)	Subscriber's ID Number:	Subscriber's Group Number:
Subscriber's Address: (street, city, state, zip)		
Patient's Relationship to Enrollee: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	Date of Service:	
Other Health Coverage		
Do you or your dependents have other health coverage? <input type="radio"/> Yes <input type="radio"/> No	If yes, what type of coverage (check all that apply): <input type="radio"/> Medical <input type="radio"/> Dental <input type="radio"/> Vision <input type="radio"/> Medicare Part A <input type="radio"/> Medicare Part B	
Other Coverage is for (check all that apply): <input type="radio"/> Subscriber <input type="radio"/> Spouse <input type="radio"/> Children	Group Number with other carrier:	Effective date with other carrier:
ID Number of other Carrier	Address of other carrier:	
Was this condition the result of an accident? <input type="radio"/> No, then sign at the bottom and return to us <input type="radio"/> Yes, please complete next section, then sign at the bottom and return to us		
Accident Injury Information (Please complete if claim is related to an accident)		
Date of Injury	Describe how and where the injury occurred	
To your knowledge who was responsible for the accident?	Was the condition the result of an auto accident? <input type="radio"/> Yes <input type="radio"/> No	
Have you received settlement from the responsible party? <input type="radio"/> Yes <input type="radio"/> No	Do you intend to make a claim against the responsible party? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Possibly	
Was this injury or illness sustained while performing work required by the patient's employment? <input type="radio"/> Yes <input type="radio"/> No	Is the patient covered by Workers' Compensation? <input type="radio"/> Yes <input type="radio"/> No	
Is the patient self employed? <input type="radio"/> Yes <input type="radio"/> No	Has the patient filed a claim with the Industrial Accident Commission? <input type="radio"/> Yes <input type="radio"/> No	
Has the patient notified his/her employer of this condition? <input type="radio"/> Yes <input type="radio"/> No	Is the patient covered by a liability coverage other than Workers' Compensation for work-incurred injuries? <input type="radio"/> Yes <input type="radio"/> No	Has the patient filed a claim with his/her employer's liability coverage? <input type="radio"/> Yes <input type="radio"/> No
Signature		
Authorized Signature Subscriber		Date

Mailing Address: PO Box 5429, Boise, ID 83705-0679
Street Address: 800 Park Blvd, Ste. 760, Boise, ID 83712
Phone Numbers: (208) 333-1580 or (866) 373-1526