SUPPLEMENTAL CLAIM STATEMENT

Group # :
Employer:

Tucker Administrators, Inc.

Instructions:
*One fully completed claim form is required from each claimant each calendar year.
*Use this form to submit additional claims.
*Attach fully itemized bills to this form and complete the information below. We will advise you if additional information is needed.
*DO NOT use this form to submit a claim for a new accident. A fully completed claim should be submitted.

Employee Name:_____Social Security Number:_____

Patient Name:_____Diagnosis:_____

Is there coverage under Medicare or other insurance?_____
(Specify)

Has employment terminated? ____Yes _____No If yes, effective date:_____

Authorized Representative's Signature_____ Date_____

NOTE - BILLS MUST HAVE THE FOLLOWING INFORMATION

1. Name of patient and the name and address of provider.
2. A complete description of each service.
3. The date of each service.
4. The amount charged for each service.
5. The diagnosis for each illness or injury.
6. Drug prescription number and drug name if known.

3800 Arco Corporate Dr. Ste. 450, Charlotte, NC 28273 Ph:704-525-9666 Fax:704-525-9534