



## Limited Benefit Health Insurance Claim Form

*Provider Bill Must Include Diagnosis*

1. Employee Name (Last, First, MI)		2. Date of Birth	3. Address		4. Employer's Name	
5. Member Phone #	7. Policy or Plan Number		9. Diagnosis for Treatment	10. Present Work Status Active                      Terminated Retired Leave of Absence COBRA		11. Date last actively at work:
6. SSN or Unique ID	8. Treatment Date of Service					
12. This claim is for (Check one box to identify the patient for the claim. If the patient is for your spouse or child, complete the information below.)						
Myself						
My Spouse	Name		Date of Birth	Male/Female	SSN:	
My Child	Name		Date of Birth	Male/Female	SSN:	
13. Is this claim for an accident? Yes/No If yes, complete 14		14. Date of Accident:		15. Was accident job related?  Yes/No		Place of Accident: Home Work Other

The statements above are true and correct to the best of my belief. I authorize any hospital or physician to furnish TCC of South Carolina, Inc. any information requested. Also, I hereby authorize my employer to release to or obtain from any organization or person or regulatory agency any information which may be necessary to determine benefits payable under the group policy. A photo static copy of this authorization shall be considered as effective and valid as the original. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

TCC of South Carolina  
PO Box 22557  
Charleston, SC 29413  
800-851-6268 Fax # 803-2649285

**USE ONLY THIS CLAIM FORM**  
Crescent 9/12