Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

MEDICAL CLAIM FORM

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

Member ID Number: _____

Insured's Name: _____ Group Number: _____
Last *First* *M.I.*

Insured's Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Work Phone: _____

Patient Name: _____ Patient Birth Date: _____
Last *First* *M.I.*

Relationship to Insured: ☐ Insured ☐ Dependent

☐ Spouse ☐ Other _____

Date of Service: _____ Provider: _____

☐ Pay to Member ☐ Pay to Provider ***(must submit unassigned claim form from provider)***

For member reimbursement attach:

- Detailed Claim from Provider
- Proof of Payment

Mail to:

Scott & White Health Plan
Attn: Pay Me
1206 West Campus Drive
Temple, TX 76502