Member Form for Claim

Please use this form when submitting claims directly to

110 S. Shipley Street
Seaford, DE 19973

Cardholder Information	Group #
Name	Phone #
Address	

Patient Name

Claim Type
- **Medical**
- **Dental**
- **Vision**

Select one:

- I have paid the provider and request payment of benefits.
- I **h**ave **not** paid the provider and I authorize and request payment of benefits to the physician/provider.

_____ _____

Signature *Date*

Return your form to us by mail, fax, or web portal.
Upload to website: https://integratpa.com/,
'Contact Us', 'Customer Service/ShareFile'
Fax: 302-629-8416