COCOPAH INDIAN TRIBE
SSA MEXICO PPO NETWORK

2400 W. Dunlap Ave., Suite 250 * Phoenix, AZ 85021 * Phone 602-249-3582 * Toll Free 1-800-474-3485 * Fax 602-249-3795
www.southwestservicetpa.com

PART A EMPLOYEE'S STATEMENT MUST BE COMPLETED BY EMPLOYEE PLEASE PRINT

1. EMPLOYEE NAME	2. BIRTH DATE MO. DAY YR.	3. PID#
4. ADDRESS ☐CHECK HERE IF NEW ADDRESS CITY STATE ZIP		5. PHONE NO.
6. CLAIM IS FOR ☐ SELF ☐ SPOUSE ☐ CHILD	7. DEPENDENT'S NAME / 8. RELATIONSHIP	9. BIRTH DATE MO. DAY YR.
10. IS THIS CLAIM FOR AN ACCIDENT? ☐ YES ☐ NO	11. IF YES - WHERE DID IT HAPPEN? / 12. WHEN? MO. DAY YR.	13. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB? ☐ YES ☐ NO

14. **EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION:**

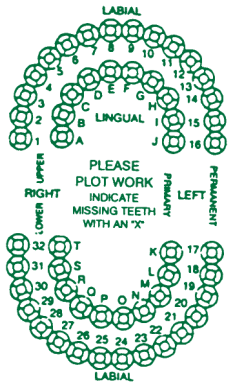
I hereby certify that the foregoing statements, including any acccompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form.

I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.

Employee Signature: X _____ **Date** _____
CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE MO. DAY YR.

PART B PROVIDER'S STATEMENT MUST BE COMPLETED BY PROVIDER MEDICAL/DENTAL FORM

1. PATIENT'S NAME	2. AGE	3. SEX
4. DIAGNOSIS OR NATURE OF DISEASE, INJURY CLAIM OR VISION DISORDER		
5. OCCUPATIONAL INJURY ☐YES ☐NO		



6. DATE OF SERVICE MO. DAY YR.	PLACE OF SERVICE	TOOTH #	SURFACE	CPT or CDT	LIST SEPARATELY: SERVICES, MATERIALS AND FITTINGS	CHARGES

NOTE: Provider ID No. (No. 7) Must Be Completed	7. PROVIDER MX#	8. TELEPHONE NO.	9. DATE	TOTAL CHARGES
10. PROVIDER'S NAME AND DEGREE (PRINT)		11. SIGNATURE X		AMOUNT PAID
12. ADDRESS	13. CITY	14. STATE	15. ZIP	BALANCE DUE

QUESTIONS? PHONE (602) 249-3582 TOLL FREE 1-800-474-3485 SE HABLA ESPAÑOL