Wellness Claim

To:	Loyal American	**From:**	
Fax:	580-255-0951	**Pages:**	
Phone:		**Date:**	

INSTRUCTIONS

ATTACH A COPY OF THE DOCTOR'S BILL SHOWING THE SERVICE PERFORMED, DATE OF SERVICE, AND CHARGE(S). FOR ASSISTANCE, CALL TOLL-FREE 800-366-8354.

Policy Number________________________**Patient**______________________________________

Date of Birth____________**Male** ☐ **Female** ☐ **Student** ☐ **If student, where?** ________________

Name and Address of Primary Insured

______________________________ **Patient is:** ☐ **Primary Insured**

______________________________ ☐ **Spouse**

______________________________ ☐ **Child**

______________________________ ☐ **Other**

P O Box 1604, Duncan, OK 73534-1604