5-29-2018

NON-NETWORK CLAIM FORM

Plan Member and Client Information

Plan Member's Name USL Member Number (Required)

Address

City, State, Zip

Plan Member Telephone Contact Number Company or Group: **CCPOA**

Relationship to Plan Member □ Self □ Spouse □ Child □ Other: DOB:

Authorized Signature

X_________________________________Date: _______________________________

I authorize the release of any legal information necessary for this claim

Claim Information

Claims must be submitted within ninety [90] days of the date of service. Claims aged ninety [90] days or older are subject to denial. Please be sure to review your policy carefully regarding use of Out of Network Attorneys and requirements for payment of Out of Network benefits. Out of Network benefits are paid one [1] time only, per legal matter.

First Contact Date: ____

Date suit or charges filed: ____

County/Civil/ Criminal Case Number: _______________________________________

Type of Legal Issue: □Civil □Family Law □Business □Bankruptcy □Administrative Hearing □Guardianship □Adoption □Juvenile □Criminal □DUI □Wills/Trust Probate □Real Estate □Traffic □Immigration

Attorney Name: ____

Address: ____

City State Zip Code:

Telephone Number:

COPIES OF ATTORNEY DETAILED INVOICE[S] AND PROOF OF PAYMENT MUST BE ATTACHED BEFORE REQUEST FOR REIMBURSEMENT CAN BE SUBMITTED FOR APPROVAL

ALL SECTIONS OF THIS CLAIM FORM MUST BE COMPLETED FOR CLAIM TO BE PROCESSED.

U. S. Legal Services, 8133 Baymeadows Way, Jacksonville, Florida 32256
844-896-LAWS[5297]/FAX 904-562-5996

By Submitting this claim, I certify I agree to the terms of the current Attorney Reimbursement Fee Schedule. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree. All claim documentation must be submitted with claim or claim for payment will be denied.