



ClaimLinx
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ID Card Request Form

NOTE: Please fax or mail to process your request.

Today's Date: _____ **# Pages** _____
(include coversheet)

Company: _____

Employee Name: _____
(Please Print Clearly – First Name, MI, Last Name)

Current Address: _____
(Street Address)

(City, State, Zip Code)

Relationship - S = Self / SP = Spouse / CH = Child
ID card type: Medical =Employer Funded Medical ID Card / Dental = Employer Funded Dental ID Card

Indicate below the Member Name and type of card that you are requesting.

	Card requested for (Member Name)	Relationship to Employee (Circle)	ID Card Type (Circle)	Quantity
1		S / SP / CH	Medical / Dental	
2		S / SP / CH	Medical / Dental	
3		S / SP / CH	Medical / Dental	
4		S / SP / CH	Medical / Dental	
5		S / SP / CH	Medical / Dental	
6		S / SP / CH	Medical / Dental	
7		S / SP / CH	Medical / Dental	