



M E D I C A L STATEMENT OF CLAIM

- Employee must submit one fully – completed claim form per patient.** All Questions in “Employee Data” and “Patient Data” sections whether claim is for employee, retired employee, spouse or dependent child **MUST** be completed. Please **DO NOT** send any bills unless they are attached to a completed claim form.
- Your Doctor **MAY** complete the “Attending Physician’s Statement” (reverse side), or you may submit bills from your doctor, hospital, and/or pharmacy with this claim form. Itemized bills **MUST** include: Patient’s name, diagnosis, service(s), date of service and charge.
- If patient is covered by Medicare**, submit **BOTH** an itemized bill and Explanation of Benefits from Medicare, to speed processing.
- Send completed claim form and related itemized medical bills to claim office address shown above.
- Please hold your charges until you have at least \$100.00 in expenses to submit for processing.

I. Employee Data

| | | | |
|--|--|------------------|---------------------------|
| 1. Name (First, Middle & Last) | 2. Sex <input type="checkbox"/> M <input type="checkbox"/> F | 3. Date of Birth | 4. Social Security Number |
| 5. Home Address Street City State ZIP Code | If this is a new address, notify your employer of any changes. | | |
| 6. Last Date active employee worked before charges for this claim began: | 7. Employee Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Layoff <input type="checkbox"/> COBRA Continuant | | |

II. Patient Data

| | | | |
|---|---|---|--|
| 8. Patient Name (First, Middle, Last) | 9. Birthdate | 10. Sex <input type="checkbox"/> M <input type="checkbox"/> F | 11. Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Incapacitated Dependent Child <input type="checkbox"/> COBRA Continuant |
| 12. Is Child 19 through 23 a Full time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. If yes, Name of School | | 14. Address of School |
| 15. Are natural parents divorced or separated? <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Do you have custody of the child? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Does natural parent WITHOUT custody have financial responsibility for health expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 18. Was this patient covered by another group health plan, Medicare, or other government plan at the time the charges were incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 19. Reason for Claim <input type="checkbox"/> Illness <input type="checkbox"/> Accident | |
| 20. If “accident,” please provide date, place and how it happened... | | | |
| 21. Was illness or accident work related? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date | Place | How it happened |

III. Spouse Data (must be completed if claim is for spouse or child)

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|--|-------------------------------------|---|
| 22. Spouse’s Name (First, Middle & Last) | 23. Spouse’s Social Security Number | 24. Spouse’s Date of Birth |
| 25. Spouse’s Employer’s Name | 26. Spouse’s Employer’s Address | 27. Spouse’s Employer’s Area Code & Phone No. () |

IV. Other Insurance Data (must be completed if covered by any other insurance)

| | | |
|---|--|---|
| 28. Name of Person Covered by Other Insurance | 29. Social Security Number | 30. Name of Company This Person Works For |
| 31. Name of Other Insurance Company | 32. Address of Other Insurance Company | 33. Group No. |

V. Authorization To Release Information – Certification of Accuracy

Upon presentation of the original or photocopy of this signed authorization, I authorize any Physician, Medical Practitioner, Hospital, Clinic, other medical or medically related facility, insurance or reinsurance company, medical information bureau, consumer reporting agency, employer, or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and or treatment of me or my dependents and any other non-medical information of me or my dependents to give my employer, third party administrator, or its plan administrator, managed care entity, or its legal representatives, any and all such information.

I understand that information obtained under this authorization shall be used to determine my eligibility for coverage and benefits and that such information may be released to persons or organizations performing business or services in connection with this claim, I also know that I may receive a copy of this authorization and that it will only be valid for 30 months.

Any persons who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a criminal and/or civil offense.

| | | | |
|----------------------|------|--|------|
| Employee’s Signature | Date | Spouse’s Signature (for dependent claims only) | Date |
|----------------------|------|--|------|

| | | | |
|-------------|--------------|-------------------|-------------|
| Control No. | Account. No. | Planholder’s Name | Verified By |
|-------------|--------------|-------------------|-------------|

TYPE OR PRINT

**ATTENDING PHYSICIAN'S
STATEMENT**

Items 4 through 8 and 11 below Need not be filled in if employee's statement on other side is completed

| PATIENT & EMPLOYEE (SUBSCRIBER) INFORMATION | | | | | | |
|--|------------------------|--|----------------------------|---|--------------|---|
| 1. Patient's name (First name, middle initial, last name) | | 2. Patient's date of birth | | 3. Employee's name (First name, middle initial, last name) | | |
| 4. Patient's address (Street, city, state, ZIP code) | | 5. Patient's sex <input type="checkbox"/> Male <input type="checkbox"/> Female | | 6. Employee's I.D., Medicare and or Medicaid no. (Include any letters) | | |
| Telephone No. | | 7. Patient's relation to employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | 8. Employee's group no. (Or group name) | | |
| 9. Other health coverage – Enter Name of Planholder or Policyholder and Plan Name and Address and Policy or Medical Assistance Number | | 10. Was condition related to A. Patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No B. An auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 11. Employee's address (Street, city, state, ZIP code) | | |
| 12 – 13. I authorize payment of medical benefits to undersigned physician or supplier for services described below as having been completed. Authorization does not extend to benefits payable for services completed after form is released by provider. SIGNED (Employee or Authorized Person) | | | | | | |
| PHYSICIAN OR SUPPLIER INFORMATION | | | | | | |
| 14. Date of: | | Illness (first symptom) or injury (accident) or pregnancy (LMP) | | 15. Date first consulted you for this condition? | | 16. Has patient ever had same or similar symptoms? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 17. Date patient able to return to work | | 18. Dates of total disability From _____ Through _____ | | Dates of partial disability From _____ Through _____ | | |
| 19. Name of referring physician or other source (e.g., public health agency) | | | | 20. For services related to hospitalization give hospitalization dates Admitted _____ Discharged _____ | | |
| 21. Name & address of facility where services rendered (if other than home or office) | | | | 22. Was laboratory work performed outside your office? Yes <input type="checkbox"/> NO <input type="checkbox"/> Charges: | | |
| 23. Diagnosis or nature of illness or injury, relate diagnosis to procedure in column D by reference to numbers 1,2,3,etc. or DX code 1. 2. 3. 4. | | | | | | |
| 24. A Date of service | B* Place of service | C Fully describe procedures, medical services or supplies furnished for each date given (explain unusual services or circumstances) | Procedure Code (Identify:) | D DX Code (ID:) | E Charges | F For insurance company or administrator use |
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| 25. Signature of physician or supplier Signed _____ Date _____ | | 26. Accept Assignment Yes <input type="checkbox"/> No <input type="checkbox"/> (Government Claims Only) | | 27. Total charges | | 28. Amount paid |
| 31. Your patient's account no. | | 30. Your social security no. | | 29. Balance due | | |
| 32. Your employer I.D. no. | | 33. Physician's or suppliers name, address, zip code & telephone no. I.D. No. | | | | |
| * Place of service codes | | | | | | |
| 1 - (IH) – Inpatient Hospital | | 4 – (H) – Patient's Home | | 7 – (NH) – Nursing Home | | O – (OL) – Other Location |
| 2 – (OH) – Outpatient Hospital | | 5 – (PSY) – Day Care Facility | | 8 – (SNF) – Skilled Nursing Facility | | A – (IL) – Independent Laboratory |
| 3 – (O) – Doctor's Office | | 6 – (PSY) Night Care Facility | | 9 – Ambulance | | B – Other Medical/Surgical Facility |