STATEMENT OF CLAIM – MEDICAL

Instructions

1. *Employee must complete PARTS A and B.*
2. *Ask patient's physician to complete reverse side of this form*
3. *Attach bills for covered expenses to this form. Bills must show: patient's name, date, type of service, and amount charged. Drug bills must also show prescription (℞) numbers, and drug name.*

PART A – Employee Information

1. Employee's name (first, middle, last)	1. Sex Male Female	3. Birthdate	4. Member ID Number
2. Home Address (street, city, state, zip)			6. Are you: Single Divorced Married Widowed
7. Name of Employer	8. Group Certificate Number		

PART B – Patient Information and Authorization to Release Information

9. Claim Is for: Self Spouse Dependent child *If "Self" skip to question 14.*	10. Patient's Name	11. Sex Male Female 12. Birthdate
13. Complete only for claims on dependent children, age 19 or older. Is child fully dependent on you for principal support and a full-time student? Yes No		14. Reason for claim Illness Accident

15a. If "Accident," please provide date, place, and how it happened in spaces below:

Date:	Place	How did it happen?

15b. If "Illness" describe nature of illness below:	Was illness or accident work related? Yes No

17. Was patient total disabled? Yes No If "Yes," give dates. From: Thru:	18. Is your spouse employed? Yes No If "Yes," complete question 19.

19. Name of spouse		Member ID Number	*FOR INSURANCE COMPANY USE*
Name, Address and Phone Number of Spouse's Employer			
20. Are you, your spouse, or your dependents covered by any other group insurance, prepaid health plan, Medicare, or other governmental plan? Yes No If "Yes," complete question 21.			
21. Insured's Name		Group insurance company or plan's name	
Certificate Number	Policy number	Group insurance company or plan's address (street, city, state, zip)	

22. AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, 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 to the group policy holder, my employer, Health Administrators, Inc. – Benefits Division, or its legal representative any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by Health Administrators, Inc. – Benefits Division to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Health Administrators, Inc. – Benefits Division to any person or organization EXCEPT to the group policyholder, my employer, third party administrator, reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two and one half years from the date shown below, or for the duration of this claim, if longer.

Date	Employee's signature	Spouse's Signature (for spouse claims only)

TYPE OR PRINT

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME (First name, middle initial, last name)

4. PATIENT'S ADDRESS (Street, city, state, ZIP code)

TELEPHONE NO.

5. PATIENT'S SEX
MALE FEMALE

6. INSURED'S I.D., MEDICARE AND/OR MEDICAID NO. (include any letters)

7. PATIENT'S RELATIONSHIP TO INSURED
SELF SPOUSE CHILD OTHER

8. INSURED'S GROUP NO. (or Group Name)

9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES NO
B. AN AUTO ACCIDENT
YES NO

11. INSURED'S ADDRESS (Street, city, state, ZIP code)

12.-13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW*

SIGNED (Employee or Dependent if over the age of 18)

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 NO

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 NO 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 SER-VICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY:)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DX CODE (ID:)	E. CHARGES	F. FOR INSURANCE COMPANY USE

25. SIGNATURE OF PHYSICIAN OR SUPPLIER

SIGNED DATE

26. ACCEPT ASSIGNMENT (Government Claims Only)
YES NO

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.

I.D. NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

*PLACE OF SERVICE CODES

1-(IH) - INPATIENT HOSPITAL
2-(OH) - OUTPATIENT HOSPITAL
3-(O) - DOCTOR'S OFFICE
4-(H) - PATIENT'S HOME
5- DAY CARE FACILITY (PSY)
6- NIGHT CARE FACILITY (PSY)
7-(NH) - NURSING HOME
8-(SNF) - SKILLED NURSING FACILITY
9- AMBULANCE
O-(OL) - OTHER LOCATIONS
A-(IL) - INDEPENDENT LABORATORY
B- OTHER MEDICAL/SURGICAL FACILITY