

MEDICAL CLAIM FORM

INSTRUCTIONS:

1. Complete Employees Statement below
2. Attach legible itemized bill
3. Please refer to your identification card for mailing instructions

EMPLOYEE'S STATEMENT

NAME OF EMPLOYEE (<i>First name, middle initial, last name</i>)		EMPLOYEE'S BIRTHDATE	EMPLOYEE'S IDNUMBER (from medical card)	
EMPLOYEE'S ADDRESS (NO.) (STREET)		(CITY)	(STATE)	(ZIP)
EMPLOYEE'S SEX MALE FEMALE	EMPLOYEE'S MARITAL STATUS SINGLE MARRIED DIVORCED LEGALLY SEPARATED			EMPLOYER NAME
IS COVERAGE FOR THIS CLAIM PROVIDED BY ANY OTHER GROUP INSURANCE, FEDERAL PROGRAM (INCLUDING MEDICARE), EMPLOYER, UNION, STUDENT OR ASSOCIATION PLAN? YES NO IF YES, PROVIDE NAME AND ADDRESS OF INSURANCE COMPANY				POLICY NUMBER
NAME OF PATIENT		PATIENT'S BIRTHDATE	PATIENT'S RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER	
PATIENT'S SEX MALE FEMALE	IF CLAIM FOR A DEPENDENT CHILD, DO YOU HAVE LEGAL CUSTODY? IS CHILD MARRIED? YES NO		YES NO	
DIAGNOSIS, NATURE OF ILLNESS OR INJURY			IS CONDITION RELATED TO EMPLOYMENT? YES NO	
WAS PATIENT INVOLVED IN AN ACCIDENT? YES or NO? IF YES, COMPLETE THE FOLLOWING THREE BOXES / IF NO, SKIP TO ASSIGNMENT				
DATE OF ACCIDENT		HOW AND WHERE DID ACCIDENT HAPPEN?		
DATE AND NAME & ADDRESS OF PHYSICIAN FIRST CONSULTED				
COMPLETE THIS BOX ONLY IF YOU WANT PAYMENT TO GO DIRECTLY TO THE PROVIDER *LEAVE THIS SECTION BLANK FOR PAYMENT TO BE MAILED DIRECTLY TO YOU*				
ASSIGNMENT: I AUTHORIZE BENEFITS UNDER THIS CLAIM TO BE PAID DIRECTLY TO THE PROVIDER OF SERVICES PROVIDED THAT THE REQUIRED TAX ID NUMBER HAS BEEN FURNISHED.				
DATE: _____		EMPLOYEE'S SIGNATURE: _____		
AUTHORIZATION: The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, practitioner or other person, any hospital, including veteran's administration or government hospital, any medical service organization, any insurance company, or other institution, or organization, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other liabilities. A photostat of this authorization shall be as valid as the original.				
DATE	EMPLOYEE'S SIGNATURE		PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR)	