

**INSTRUCTIONS**

- (1) Complete the Employee Section below. Have patient complete Part A on the reverse side. Have patient's physician complete Part B on the reverse side.
- (2) Attach itemized bills for expenses not shown in Part B.
- (3) If you want benefits paid directly to physician, complete the Authorization to Pay on reverse side.
- (4) Return to the above address AS SOON AS POSSIBLE.

**Notice to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts.**

**TO BE COMPLETED BY EMPLOYEE**

|   |                       |        |  |  |  |   |   |   |  |
|---|-----------------------|--------|--|--|--|---|---|---|--|
| Name and Home Address of Employee (Please Print)<br>Mr.<br>Mrs.<br>Miss.<br><input type="checkbox"/> Check here if your address has changed     |                       | Number |  | Street   |  |   |   |   |  |
|   |                       | City   |  | State  |  | Zip Code                                      |   |   |  |
| ID No.  |                       |        | Sex<br><input type="checkbox"/> M<br><input type="checkbox"/> F  | Marital Status:<br><input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br><input type="checkbox"/> Married <input type="checkbox"/> Legally Separated |  | Your Date of Birth<br>Mo    Day    Yr         |   | Spouse's Date of Birth<br>Mo    Day    Yr |  |
| Group #   | Name of Your Employer |        | At the time charges were incurred:<br>Was your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If claim is for any child,<br>was the child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No |  | Name and Address of Spouse's Employer                        |   |   |   |  |
| Dependent Information / Complete only if Patient is a Dependent   |                       |        |  |  | Spouse's Social Security Number                              |   |   |   |  |
| Name of Dependent   |                       |        | Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child<br><input type="checkbox"/> Other _____ (relationship)  |  | Sex<br><input type="checkbox"/> M <input type="checkbox"/> F |   | Marital Status of Child:<br><input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br><input type="checkbox"/> Married <input type="checkbox"/> Legally Separated |   |  |
| If claim is for dependent child 19 or older, is child enrolled as a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |        | Name of School   |  |  | Child's Date of Birth<br>Month    Day    Year |   |   |  |

**FAILURE TO COMPLETE THIS SECTION WILL REQUIRE THE PLAN TO RETURN FORM.**

|  |  |                       |  |  |                      |
|--|--|-----------------------|--|--|----------------------|
| Nature of Illness or injury  |  |                       | Date of First Treatment  |  |                      |
| Is this claim based on an accident?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | If yes, give date     |  | Time <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. |                      |
| Where did accident occur?  |  |                       | How did accident happen?   |  |                      |
| Is this condition due to injury or sickness arising out of employment?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                 |  |                       | Was injury the result of an automobile accident?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |                      |
| Are you taking legal action?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | If yes, Lawyer's Name |  | Lawyer's Address   |                      |
| Are you or your dependent/spouse covered under any other group plan?<br>(including Blue Cross & Blue Shield, Student Accident or Government Plan?) |  |                       |  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No      |                      |
| Give name of person covered  |  | Relationship          |  | Effective date   | Plan Name and Number |

I CERTIFY THAT ALL THE ANSWERS ON THIS APPLICATION ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I FURTHER UNDERSTAND THAT ANY FALSE STATEMENT MAY DISQUALIFY ME FOR ANY BENEFITS AND THE PLAN ADMINISTRATOR SHALL HAVE THE RIGHT TO RECOVER ANY PAYMENTS MADE TO ME IN RELIANCE UPON ANY FALSE STATEMENT.

I authorize any physician, hospital, employer, or insurance company to furnish and disclose all known facts concerning this claim for myself, my spouse, or dependent children. A copy or photocopy of this authorization shall be as valid as the original.

Date \_\_\_\_\_ Employee's Signature

**FOR ADMINISTRATIVE USE ONLY**

|   |               |                  |  |  |
|---|---------------|------------------|--|--|
| WE CERTIFY THAT THE PATIENT IS COVERED BY OUR GROUP CONTRACT AS INDICATED BY SUBSCRIBER ABOVE AND IS ELIGIBLE FOR BENEFITS. | DATE ELIGIBLE | TERMINATION DATE | TYPE OF CONTRACT<br><input type="checkbox"/> IND <input type="checkbox"/> FAMILY | AUTHORIZATION TO PAY BENEFITS          |
|   | EMPLOYER      |                  |  | SIGNATURE _____ TITLE _____ DATE _____ |

GROUP MEDICAL CLAIM

| <b>PART A</b>   |     |      |                    |  |  | <b>TO BE COMPLETED BY PATIENT (INSURED)</b>   |  |                             |  |   |  |                              |  |                             |  |
|---|-----|------|--------------------|--|--|---|--|-----------------------------|--|---|--|------------------------------|--|-----------------------------|--|
| PATIENT'S NAME  |     |      |                    |  |  | Employee's Social Security No.  |  |                             |  |   |  |                              |  |                             |  |
| AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonably and customary charge for those services. |     |      |                    |  |  | SIGNED (INSURED PERSON)<br>DO NOT SIGN HERE IF YOU HAVE PAID PHYSICIAN  |  |                             |  |   |  |                              |  |                             |  |
|   |     |      |                    |  |  | DATE  |  |                             |  |   |  |                              |  |                             |  |
| AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.  |     |      |                    |  |  | SIGNED (PATIENT, OR PATIENT IF MINOR)   |  |                             |  |   |  |                              |  |                             |  |
|   |     |      |                    |  |  | DATE  |  |                             |  |   |  |                              |  |                             |  |
| <b>PART B</b>   |     |      |                    |  |  | <b>ATTENDING PHYSICIAN'S STATEMENT</b>  |  |                             |  |   |  |                              |  |                             |  |
| DIAGNOSIS AND CONCURRENT CONDITIONS<br>(IF DIAGNOSIS CODE OTHER THAN ICD-9* USED, GIVE NAME):   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
| IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?<br><br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |     |      |                    |  |  | PREGNANCY?<br><br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                             | IF YES, APPROXIMATE DATE<br>PREGNANCY COMMENCED: |   |  |                              |  |                             |  |
| DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.  |     |      |                    |  |  | DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.  |  |                             |  |   |  |                              |  |                             |  |
| PATIENT EVER HAD SAME OR SIMILAR CONDITION?<br><br>YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" WHEN AND DESCRIBE:   |     |      |                    |  |  | PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?<br><br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |   |  |                              |  |                             |  |
| DOES PATIENT HAVE OTHER HEALTH COVERAGE?<br>IF "YES" PLEASE IDENTIFY  |     |      |                    |  |  | YES <input type="checkbox"/>  |  | NO <input type="checkbox"/> |  | I ACCEPT ASSIGNMENT   |  | YES <input type="checkbox"/> |  | NO <input type="checkbox"/> |  |
| REPORT OF SERVICES (OR ATTACH ITEMIZED BILL)  |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
| DATE OF SERVICES  |     |      | PLACE OF SERVICES† |  | DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED |   |  |                             |  | PROCEDURE CODE<br>(IF CODE OTHER THAN<br>CPT** USED, GIVE NAME) |  | CHARGES                      |  |                             |  |
| Month   | Day | Year |                    |  |  |   |  |                             |  |   |  | \$                           |  |                             |  |
|   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
|   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
|   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
|   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
|   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
|   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
|   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
| †O-Doctor's Office      IH-Inpatient Hospital      NH-Nursing Home  |     |      |                    |  |  | TOTAL CHARGES ▶ \$ _____<br><br>AMOUNT PAID ▶ \$ _____<br><br>BALANCE DUE ▶ \$ _____                              |  |                             |  |   |  |                              |  |                             |  |
| H-Patient's Home      OH-Outpatient Hospital      OL-Other Locations  |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
| *ICD-9-International Classification of Diseases<br>**CPT-Current Procedural Terminology (current edition)   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |
| PHYSICIAN'S SIGNATURE   |     |      |                    |  |  | DATE  |  |                             | PHYSICIAN'S NAME AND ADDRESS                     |   |  |                              |  |                             |  |
| DEGREE  |     |      |                    |  |  | SPECIALTY   |  |                             |  |   |  |                              |  |                             |  |
| TELEPHONE   |     |      |                    |  |  | TAXPAYER ID NUMBER  |  |                             |  |   |  |                              |  |                             |  |
|   |     |      |                    |  |  |   |  |                             |  |   |  |                              |  |                             |  |