

GROUP MEDICAL CLAIM

PART A						TO BE COMPLETED BY PATIENT (INSURED)								
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) 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								
PART B						ATTENDING PHYSICIAN'S STATEMENT								
DIAGNOSIS AND CONCURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICD-9* USED, GIVE NAME):														
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>						PREGNANCY? YES <input type="checkbox"/> NO <input type="checkbox"/>			IF YES, APPROXIMATE DATE PREGNANCY COMMENCED:					
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.						DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.								
PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" WHEN AND DESCRIBE:						PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/>								
DOES PATIENT HAVE OTHER HEALTH COVERAGE? 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 (IF CODE OTHER THAN CPT** USED, GIVE NAME)		CHARGES		
Month	Day	Year										\$		
†O-Doctor's Office IH-Inpatient Hospital NH-Nursing Home						TOTAL CHARGES ▶ \$ _____ AMOUNT PAID ▶ \$ _____ BALANCE DUE ▶ \$ _____								
H-Patient's Home OH-Outpatient Hospital OL-Other Locations														
*ICD-9-International Classification of Diseases **CPT-Current Procedural Terminology (current edition)														
PHYSICIAN'S SIGNATURE						DATE			PHYSICIAN'S NAME AND ADDRESS					
DEGREE						SPECIALTY								
TELEPHONE						TAXPAYER ID NUMBER								