


Medical Claim Form

1. Complete this form
2. Enclose all bills
3. Mail or fax to 

THIS FORM TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME		SOCIAL SECURITY NUMBER		NAME OF EMPLOYER EMPLOYERS RESOURCE	
HOME ADDRESS		EMPLOYEE BIRTH DATE		GROUP # 22204034	
CITY & STATE		ZIP		IS PATIENT FULL TIME STUDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PATIENT NAME (IF OTHER THEN EMPLOYEE)		IS PATIENT COVERED BY MEDICARE? YES <input type="checkbox"/> NO <input type="checkbox"/>		PHONE NUMBER HOME _____ WORK _____	
IS PATIENT EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, NAME AND ADDRESS OF EMPLOYER _____		MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		PATIENT RELATIONSHIP TO EMPLOYEE	
IS SPOUSE EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, NAME AND ADDRESS OF EMPLOYER _____		PATIENT BIRTH DATE		IS PATIENT MARRIED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
DATE ACCIDENT OR SICKNESS BEGAN		IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN? _____ _____ _____		WAS MOTOR VEHICLE INVOLVED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
NATURE OF SICKNESS, INJURY, DIAGNOSIS OR MEDICAL CALL _____				DID ACCIDENT HAPPEN AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PHYSICIAN'S NAME					
ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THE EXPENSE OF THIS CLAIM? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE NAME, ADDRESS & POLICY # OF PLAN PROVIDING BENEFITS: NAME AND ADDRESS _____ POLICY NO. _____					
A. AUTHORIZATION TO RELEASE INFORMATION: I certify that this information is complete and accurate and authorize release of medical information necessary to process this claim. A photocopy of this authorization shall be as valid as the original. x _____ PATIENT, PARENT, OR AUTHORIZED PERSON			B. AUTHORIZATION OF PAYMENT: DO NOT SIGN IF BENEFITS ARE TO BE PAID TO THE MEMBER I authorize payment of medical benefits directly to the physician, supplier, or provider of record for the services described above. x _____ PATIENT, PARENT, OR AUTHORIZED PERSON		

INSTRUCTIONS

1. Do your provider's bills indicate what services were rendered and for whom?
2. Have you answered all the questions that are applicable to your claim?

How to file a claim

1. Complete, date and sign the Employee's Statement on this claim form. If all questions are not answered, this may delay consideration of your claim.
2. Before mailing or faxing be sure to include this claim form along with all bills for which you are filing a claim.

IMPORTANT

Each bill must show (a) name of patient, (b) date and charge for each service rendered, (c) the diagnosis for each item of expense, and (d) the type of service. If benefits are being claimed for drugs, the drug bills should show the prescription numbers, name of patient, date and charge for each prescription.

Do not present cancelled checks or cash receipts. The do not contain the information needed to process a claim. Incomplete information will only delay payment.

Don't forget to complete the claim form information above