

HEALTH CLAIM FORM

INSTRUCTIONS

THIS SIDE OF THE FORM MUST BE COMPLETED IN FULL. Attach this form to itemized bills for all expenses being claimed. The bills must show: Patient's Name, Type of Service, Date(s) of Service(s), and the Total Charge. If you are submitting a surgical bill or if the bills are for a major illness, accident, or hospitalization the reverse side of this form must be completed by the attending physician. **AVOID DELAY - ANSWER ALL QUESTIONS.**

EMPLOYEE INFORMATION		
EMPLOYEE NAME: (PLEASE PRINT FIRST NAME, MIDDLE INITIAL, LAST NAME)		SOCIAL SECURITY NO.
STREET ADDRESS: (STREET, CITY, STATE, ZIP CODE)		DATE OF BIRTH: MONTH/DAY/YEAR
EMPLOYER'S NAME		GROUP NO.

EMPLOYMENT STATUS: ACTIVE RETIRED LAID OFF
 DISABILITY LEAVE OTHER

MARITAL STATUS: SINGLE MARRIED DIVORCED
 WIDOWED LEGALLY SEPARATED

DEPENDENT'S INFORMATION: (Complete Only If Patient Is A Dependent)		
NAME OF DEPENDENT	RELATIONSHIP <input type="checkbox"/> OTHER (EXPLAIN) _____ <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	MARITAL STATUS (OTHER THAN SPOUSE)
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	DATE OF BIRTH: MONTH/DAY/YEAR
AT TIME CHARGES WERE INCURRED (IF ANSWER TO EITHER IS YES, GIVE EMPLOYER'S NAME AND ADDRESS)		
WAS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF CLAIM WAS FOR CHILD, WAS CHILD EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

COMPLETE FOR ALL PATIENTS	
DIAGNOSIS OR NATURE OF INJURY	
WHEN WHERE YOU FIRST TREATED FOR THIS CONDITION? (MONTH, DAY, YEAR)	NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED YOU
IS PATIENT ALSO COVERED FOR BENEFITS BY: a. Other Group Health Insurance of any kind including Blue Cross and Blue Shield? <input type="checkbox"/> YES <input type="checkbox"/> NO b. Group prepayment arrangement providing for medical care and treatment <input type="checkbox"/> YES <input type="checkbox"/> NO c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? <input type="checkbox"/> YES <input type="checkbox"/> NO d. No fault automobile insurance as a result of injuries sustained in an automobile accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS ILLNESS OR INJURY DUE IN ANY WAY: a. To the patient's occupation? <input type="checkbox"/> YES <input type="checkbox"/> NO b. To an automobile accident? <input type="checkbox"/> YES <input type="checkbox"/> NO c. To any other type of accident? <input type="checkbox"/> YES <input type="checkbox"/> NO
If any of the above answered YES please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency.	
REMARKS	
ACCIDENT	
DATE (TIME: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.)	(PLACE OF ACCIDENT <input type="checkbox"/> WORK <input type="checkbox"/> OTHER)
HOW DID ACCIDENT HAPPEN?	NAME AND ADDRESS WHERE ACCIDENT OCCURRED
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits to Physician or supplier for services described within.	SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information necessary to process this claim.	SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____
EMPLOYEE SIGNATURE	PATIENT SIGNATURE (UNLESS MINOR) _____ DATE _____

