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MAIL TO:
Address Indicated On
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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:

Employment Status
☐ Active ☐ Retired ☐ Laid Off ☐ Disability Leave ☐ Other

Employee Name (Please print first name, middle initial, last name)	I.D. Number:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Street Address: (street, city, state, zip code)		Date of Birth: Month/Day/Year
Employer's Name:		Group Number:

DEPENDENT'S INFORMATION: (complete only if patient is a dependent)

Name of Dependent:	Relationship: ☐ Other (Explain) ☐ Spouse ☐ Child _____
Marital Status (other than spouse):	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? ☐ Yes ☐ No If claim was for child, was child employed? ☐ Yes ☐ No

COMPLETE FOR ALL PATIENTS:

Diagnosis or nature of injury:

When were 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:	**Was illness or injury due in any way:**
a. Other Group Health insurance of any kind including Blue Cross and Blue Shield? ☐ Yes ☐ No	a. To the patient's occupation? ☐ Yes ☐ No
b Group prepayment arrangement providing for medical care and treatment? ☐ Yes ☐ No	b. To an automobile accident? ☐ Yes ☐ No
c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? ☐ Yes ☐ No	c. To any other type of accident? ☐ Yes ☐ No
d. No fault automobile insurance as a result of injuries sustained in an automobile accident? ☐ Yes ☐ No	
If any of the above are answered YES please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency.	**If any of above are answered "Yes" give details under "Accident."**

Remarks:

Accident:

Date: (Time: ☐A.M. ☐P.M.) (Place of accident: ☐Work ☐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 _____

STOP — If attaching an itemized statement, do not complete this side.

Itemized statements must show Physician's name and address, dates and types of services, charges, patient's name and diagnosis.

Patient's Name (First/MI/Last)	Patient's Birth Date (Mo/Day/Yr)	Employee's I.D. Number:

VERIFICATION OF SERVICES

In order to process your bill for services as part of your patient's claim for healthcare expense reimbursement, we require the following data. **Your cooperation is appreciated.**

PHYSICIAN OR SUPPLIER INFORMATION

Date of:	ILLNESS (first symptoms), or INJURY (Accident), or PREGNANCY (LMP)	Date patient first consulted you for this condition?	Has patient ever had same or similar symptoms? ☐ Yes ☐ No

Provider of care: (Please check) ☐ Attending ☐ Surgeon ☐ Consulting	If other than attending, give name of referring physician
Name & address of facility where services rendered (if other than home or office)	For services related to hospitalization, give hospitalization dates. ADMITTED DISCHARGED

DIAGNOSIS Please indicate ICD9-CM or DSM III codes.

PRIMARY **SECONDARY**

Date of Service	Place of Service*	CPT Procedure (identify)	Fully describe procedures, types of therapy, or services furnished for each date given, indicate whether primary or secondary (if mental therapy indicate length of session)	Charges	Amount Paid	**Balance Due**

Signature of Provider Date Signed Degree	Total Charge	Amount Paid	**Balance Due**

Your patient's account number	Provider I.D. number	Provider's name, address, zip code, and telephone number

If the services were rendered by a psychiatric worker, the following certification must be completed by the attending physician.

Therapy performed by _____

was conducted at my direction and under my supervision and I have consulted with the Therapist regarding the patient within the last 90 days. Further, I have reviewed and approved the Plan of Treatment and have examined the patient on the date indicated below.

Name of Attending Physician

Date of Examination

Address of Attending Physician

Attending Physician's Signature

Professional Status

***Place of service codes**

1 - (IH) Inpatient Hospital
2 - (OH) Outpatient Hospital
3 - (O) Doctor's Office
4 - (H) Patient's Home
5 - Day Care Facility (Psy)
6 - Night Care Facility (PSY)
7 - (NH) Nursing Home
8 - (SNF) Skilled Nursing Facility
9 - Ambulance
O - (OL) Other Location
A - (IL) Independent Laboratory
B - Other Medical Surgical Facility