bac

GROUP MEDICAL CLAIM FORM

INSTRUCTIONS: ANSWER ALL QUESTIONS FULLY, ATTACH ITEMIZED BILLING, AND FORWARD TO BAC AT: PO BOX 107, REYNOLDSBURG, OH 43068-0107 FOR PROCESSING.

A. STATEMENT OF COVERED EMPLOYEE: PLEASE ANSWER ALL QUESTIONS FULLY

1. EMPLOYEE'S NAME (LAST, FIRST, M.): | DATE OF BIRTH (MM/DD/YYYY): | I.D. NUMBER:

2. HOME ADDRESS: | CITY: | STATE: | ZIP CODE:

3. SEX: ◯ **MALE** ◯ **FEMALE**

   MARITAL STATUS: ◯ **SINGLE** ◯ **MARRIED** ◯ **DIVORCED** ◯ **WIDOWED**

   IS THIS A NEW ADDRESS?: ◯ **YES** ◯ **NO**

4. EMPLOYER:

   STATUS: ◯ **ACTIVE** ◯ **RETIRED** ◯ **COBRA**

5. SPOUSE'S NAME (LAST, FIRST, M.): | SPOUSE'S D.O.B. (MM/DD/YYYY):

6. IS SPOUSE EMPLOYED?: ◯ **YES** ◯ **NO**

   SPOUSE'S EMPLOYER:

7. ADDRESS OF SPOUSE'S EMPLOYER: | CITY: | STATE: | ZIP CODE:

8. **IF AUTO ACCIDENT...**

   PATIENT WAS THE:
   - ◯ **OWNER**
   - ◯ **DRIVER**
   - ◯ **PASSENGER**
   - ◯ **PEDESTRIAN**
   - ◯ **OTHER:**

   VEHICLE TYPE:
   - ◯ **PRIVATE PASSENGER**
   - ◯ **TAXI**
   - ◯ **BUS**
   - ◯ **TRUCK**
   - ◯ **OTHER:**

   NAME OF THE VEHICLE OWNER:

   NAME OF THE INSURANCE CO.

   POLICY NO.

   STATE IN WHICH ACCIDENT OCCURRED:

9. FOR ALL ACCIDENTS: DOES THE PATIENT EXPECT TO RECEIVE, OR HAS THE PATIENT RECEIVED, PAYMENT FOR THESE EXPENSES FROM ANOTHER SOURCE AS A RESULT OF A LAWSUIT, WORKMEN'S COMPENSATION OR SETTLEMENT? ◯ **NO** ◯ **YES, ANSWER NO. 10**

10. IF YES, PLEASE PROVIDE DETAILS:

12. DESCRIBE INJURY OR CONDITION COMPLETELY (IF INJURY INCLUDE HOW, WHEN, & WHERE.): | DATE OF INJURY OR SICKNESS:

13. NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED THIS CONDITION: | FIRST TREATMENT DATE:

14. IS INJURY OR SICKNESS DUE TO EMPLOYMENT: ◯ **YES** ◯ **NO**

    IF YES, HAVE YOU OR YOUR DEPENDENT FILED FOR WORKMEN'S COMPENSATION:

15. ARE YOU OR YOUR DEPENDENT COVERED UNDER ANY OTHER GROUP MEDICAL PLAN (INCLUDING BLUE CROSS & BLUE SHIELD), STUDENT OR GOVERNMENT PLAN? (I.E. MEDICARE, MEDICAID, TRICARE): ◯ **NO** ◯ **YES – PLEASE, COMPLETE NEXT 4 FIELDS**

    NAME OF OTHER INSURANCE COMPANY: | COMPANIE'S PHONE NUMBER: | PLAN NUMBER:

    ADDRESS OF OTHER INSURANCE COMPANY: | EFFECTIVE DATE:

COMPLETE SECTION B (CLAIM FOR DEPENDENT) AND ALL AUTORIZATIONS ON BACK OF PAGE

B. CLAIM FOR DEPENDENT: (COMPLETE SEPARATE FORM FOR EACH DEPENDENT FOR WHICH YOU ARE FILLING A CLAIM)

16. DEPENDENT'S NAME (LAST, FIRST, M.): | DATE OF BIRTH (MM/DD/YYYY):

17. DOES DEPENDENT RESIDE WITH EMPLOYEE: ◯ YES ◯ NO, PROVIDE ADDRESS: | RELATIONSHIP TO EMPLOYEE:

18. IS DEP. EMPLOYED: ◯ NO ◯ F-T ◯ P-T | IS CHILD MARRIED: ◯ YES ◯ NO | IF OVER 19, IS CHILD A FULL-TIME STUDENT: ◯ NO ◯ YES, WHERE: | DATE OF CURRENT ENROLLMENT:

C. AUTHORIZATIONS:

19. **I hereby authorize any Physician, Hospital, Insurance Company, Employer, or Organization to release any information regarding the medical history, treatment, disability, or benefits payable.**

A photo-stat of this authorization shall be as valid as the original.

This authorization shall extend to my spouse and dependents.

X _____ _____
EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

X _____ _____
SPOUSE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

20. **AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the provider of the medical and/or hospital benefits, if any, otherwise to me for the services but not to exceed the reasonable and customary charge for those services.**

X _____ _____
EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

FOLD HERE FOR USE WITH A NO. 10 WINDOW ENVELOPE

bac

FEEL FREE TO CONTACT US WITH ANY QUESTIONS OR COMMENTS:

ON THE WEB: **WWW.BACTPA.COM**
TOLL FREE: **1.800.521.2654**
FACSIMILE: **1.614.863.0184**

ANSWER ALL QUESTION FULLY, ATTACH ITEMIZED BILLING, AND MAIL TO BAC FOR PROCESSING:

BUSINESS ADMINISTRATORS & CONSULTANTS, INC.
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REYNOLDSBURG, OH 43068-0107