Patient Claim Form

Information must be printed or typewritten. Claim form must be completed and returned to us at the indicated address.

Medicare Patients: Submit this claim to Medicare FIRST! A copy of the Medicare Explanation of Benefits must be submitted with this claim form.

TO BE COMPLETED BY MEMBER

1. Information Pertaining To Member				
Name: Last, First, M.I.		Sex:	Date Of Birth	Member ID #
Home Address: Street	City	State	Zip	Telephone Number
Marital Status	Name Of Spouse		Spouse's Date Of Birth	Member ID #
Is Spouse Employed?	If Yes, Name And Address Of Employer			Employer Phone Number

2. Information Pertaining To Patient				
Patient Name: Last, First, M.I.		Sex	Date Of Birth	Member ID #
Home Address: Street	City	State	Zip	Telephone Number
Is Patient Employed? Full-Time Part Time No	Relationship To Employee?		If Dependent Child Over 19, Name Of School Where Full-time Student:	

3. Information Regarding Current Treatment			
Related To Illness?	Related To Pregnancy?	Related To Work?	Description Of Illness Or Injury
Date Of Accident	Where Happened?	Describe Accident	

4. Information Regarding Insurance		
Are You, Your Spouse or Dependent Children Covered By Any Other Insurance?	Name Of Insured	
If Yes, Name And Address Of Insurance		Insurance Phone Number

Patient's Or Guardian's Signature

I certify that the above information is true and correct and I authorize the release of any medical information necessary to process this claim.

Signed: Date:

Assignment of Benefits:

I assign payment of benefits to the following provider:

Address: Street	City	State	Zip	Telephone Number

TO BE COMPLETED BY PHYSICIAN

Patient's Name: Last, First, M.I.

Home Address: Street City State Zip | Telephone Number

Is Condition Due To Illness? Injury? Work Related? | Pregnancy? If Yes, Date Of Last Menstrual Period

Diagnosis Or Nature Of Illness Or Injuries. Give Description And ICD-9 Code.

Date Of Service	Place Of Service	Description Of Medical Services Or Supplies Provided	CPT® Code	ICD-9-CM Code	Charge

Date Of First Symptoms	Date Of Accident	Date Patient First Seen		Total Charges	
Dates Patient Unable To Work From To:	If Still Disabled, Date Patient Should Return To Work			Amount Paid	
Patient Still Under Care For This Condition?	Date Of Same Or Similar Illness Or Condition	Does Patient Have Other Health Coverage?			

Under Section 6019 Of The Internal Revenue Code, Recipients Of Medical Payments Must Provide Identifying Numbers To Payors Who Must Report Such Payments To The Internal Revenue Service. Taxpayer ID Number: _____ Social Security Number: _____

Physician's Name: _____ Signature: _____

_____

Street Address City State Zip

INFORMATION REGARDING THIS CLAIM FORM

A Separate Claim Must Be Filed For Each Different Injury Or Illness.

A Claim Must Be Filed Within 90 Days of The Date Of Service Or Claim Benefits May Be Reduced.

If Patient Is Medicare Eligible, Claim Must First Be Submitted To Medicare For Payment. We Cannot Process Claim Without Information Regarding Medicare's Payment.