Medical Claim Form

To File a Claim: This claim form must be completed by the Policyholder/Claimant. If additional space is needed, please attach a separate piece of paper with additional information. Return this claim form with a **HCFA 1500** (physician charges) or **UB 92** (facility charges) claim form to the address below. Attach an **EXPLANATION OF BENEFITS (EOB**) provided by the insurer for your Major Medical plan to this form.

Please read the authorization section and sign in the space provided. The authorization will help us obtain any additional information needed to complete the processing of your claim. Failure to sign this form will delay processing of your claim.

Send all claims to: **Planned Administrators, Inc.**
Attn: Claims
PO Box 6927
Columbia, SC 29260-6927

EMPLOYEE INFORMATION

EMPLOYEE'S NAME_____ GROUP NUMBER. _____

UMID NUMBER *(on front of ID card)*: _____ DATE OF BIRTH __ __/__ __/__ __ SEX: ☐ M ☐ F

ADDRESS: _____

PHONE NUMBER: _____ EMPLOYER NAME:_____

CLAIMANT INFORMATION

CLAIMANT'S NAME: _____

UMID NUMBER: _____ DATE OF BIRTH __ __/__ __/__ __ SEX: ☐ M ☐ F

RELATIONSHIP TO POLICYHOLDER: ☐ SELF ☐ SPOUSE ☐ DAUGHTER ☐ SON ☐ OTHER (SPECIFY)_____

IF THE CLAIMANT IS YOUR CHILD AND UNDER AGE 26, IS HE/SHE COVERED UNDER YOUR MAJOR MEDICAL PLAN? ☐ YES ☐ NO

IF YES, LIST POLICY INFORMATION BELOW.

NAME AND ADDRESS OF INSURANCE COMPANY *POLICY NUMBER*

_____

CLAIM INFORMATION

DESCRIBE INJURY OR SICKNESS (IF INJURY, DESCRIBE HOW ACCIDENT OCCURRED)

_____

_____

WHEN DID THE ACCIDENT OR SICKNESS FIRST OCCUR? _____

IS INJURY OR SICKNESS DUE TO EMPLOYMENT? ☐ YES ☐ NO IF YES, PLEASE PROVIDE DETAILS:

_____

_____

Questions? Call the MediHop toll-free Customer Service Line, 1-800-565-8215, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

Companion Life

The plan is underwritten by Companion Life Insurance Company, Columbia, South Carolina

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The plan is administered by Planned Administrators, Inc., P.O. Box 6702 Columbia, South Carolina 29260

PROVIDER INFORMATION

NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED THIS CONDITION:

_____

_____

_____

PHONE NUMBER ( ) _____ FAX NUMBER ( ) _____

HOSPITAL/OUTPATIENT FACILITY INFORMATION

HOSPITAL / OUTPATIENT FACILITY NAME_____

ADDRESS_____

CITY/STATE/ZIP CODE_____

PHONE NUMBER ( ) _____ FAX NUMBER ( ) _____

DATE SEEN/ADMITTED: __ __/__ __/__ __ __ __ DATE DISCHARGED: __ __/__ __/__ __ __ __

AUTHORIZATION

Instructions: The authorization should be completed and signed by the insured. If the insured in unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin. To all physicians, hospitals, medical service providers, pharmacists, employers, consumer reporting agencies, law enforcement agencies, and any other agencies or organizations (including other insurance companies, Social Security Administration, BlueCross BlueShield, self-insured and prepaid health plans), you are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and its authorized representatives to view and obtain copy of ALL RECORDS, including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including information relating to mental illness, drug or alcohol treatment, HIV (AIDS virus) and disease.

Name of Policyholder _____ Name of Claimant _____

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

Signature of Policyholder _____ Signature of Claimant _____ Date: _____

(If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.)

Legal Guardian Name

_____

Relationship to insured if signed by other than insured

_____

Address_____

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