Principal® Financial Group

Administered by
Principal Life Insurance Company

Medical Claim

Most claims are filed by doctors and hospitals and you may not need a form. If your doctor or hospital requires one, complete this form and send it to the address on your ID card. Sending it to the home office of Principal Life Insurance Company (Principal Life) will delay processing. For information about a claim, please call your claim center toll-free number on your ID card.

Please note:

- Provide information as indicated to avoid delay in the processing of this claim.
- If the hospital requests verification of coverage, the hospital may call Principal Life toll free nationwide **1-800-247-4695**.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

Part A. Employee Information

Employee's name (first, middle, last) | **Plan and I.D. numbers (printed on I.D. card)** Plan I.D. | Employee's birth date

Employee's employer | Employee's employment date | Is employee still working ☐ yes ☐ no | If "no," give date last worked

Is employee
☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Part B. Patient Information (Complete a separate form for each patient.)

For whose expenses is claim being made? (If patient is other than self, answer questions 1-8 in this section.)
☐ self (if "self," go to questions 4, 5, 6, 7, 8) ☐ wife ☐ husband ☐ son ☐ daughter ☐ stepchild ☐ foster child

1. Patient's birth date | 2. Patient's name (first, middle, last)

3. Patient's occupation (if patient is over age 18 and a student, please indicate name and address of school)

3a. Student's social security number | 3b. Number of hours or units being taken by student | 4. This claim is the result of ☐ illness ☐ injury | 5. Is it employment related ☐ yes ☐ no

6. Date occurred | 7. If injury, place it happened

8. Describe illness/injury

Part C. Other Insurance Information

(Complete if: a. this is the first claim for this illness or injury - or –
b. you have not submitted a completed claim form in the last six months.)

If employee is married, give spouse's name (if other than patient) | Spouse's birth date (if other than patient)

Spouse's social security number | Is spouse employed? ☐ yes ☐ no | If "yes," give name, address and telephone number of spouse's employer

If "yes," does spouse's employer provide group medical coverage ☐ yes ☐ no | If "yes," please list any family members covered by this plan

If "no," please explain

If patient is covered by any other medical plan, group policy, prepayment plan, Medicare or other government plan, please provide the following information:

Name of person(s) carrying the other coverage | Name of group (employer, association, etc.)

Policy or plan number | Name and address of insurance company or plan

These statements are true and complete to the best of my knowledge.

▶ Signature of employee | Date

Part D. Authorization for Release of Information (Complete for every claim.)

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Principal Life and the planholder, or their representatives, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization.

Signature of employee | Date

Signature of patient (required only if patient is spouse) | Date

Address of employee (street number) | (city)

(state) | (ZIP code) | Is this a new address ☐ yes ☐ no | Please furnish a daytime telephone number in case we need to reach you

Medical Claim Form (Read directions before completing this form.)

Authorization to Pay (Sign here only if you want benefits paid directly to patient's doctor, hospital, or other provider of medical care.)

I authorize payment of medical benefits to physician or supplier for service described below or on attached bill.

Signed (authorized person) | Date

1. Attach an itemized bill including diagnosis **– or –** 2. Have patient's physician or supplier complete their portion of this form below.

Patient's name (first, middle, last)

9. DATE OF CURRENT: MM DD YYYY ◀ Illness (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)	10. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YYYY	11. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YYYY FROM MM DD YYYY TO
12. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	12A. I.D. NUMBER OF REFERRING PHYSICIAN	13. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YYYY FROM MM DD YYYY TO
14. RESERVED FOR LOCAL USE		15. OUTSIDE LAB? ☐ Yes ☐ No $ CHARGES
16. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 or 4 TO ITEM 19E BY LINE.) 1. ___ • ___ 3. ___ • ___ 2. ___ • ___ 4. ___ • ___		17. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		18. PRIOR AUTHORIZATION NUMBER

19.	A DATE(S) OF SERVICE From MM DD YYYY	A To MM DD YYYY	B Place of Service	C Type of Service	D Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT/HCPCS	D MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1													
2													
3													
4													
5													
6													

20. FEDERAL TAX I.D. NUMBER ☐ SSN ☐ EIN	21. PATIENT'S ACCOUNT NO.	22. ACCEPT ASSIGNMENT ☐ YES ☐ NO	23. TOTAL CHARGE $ / 24. AMOUNT PAID $ / 25. BALANCE DUE $
28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS SIGNED DATE	27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		28. PHYSICIAN'S SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN # GRP#

*PLACE OF SERVICE CODES

1 – (H) – INPATIENT HOSPITAL
2 – (OH) – OUTPATIENT HOSPITAL
3 – (C) – CLINIC
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 LOCATIONS
A – (IL) – INDEPENDENT LABORATORY
B – – OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88