THE WORLD BANK GROUP

# CLAIM FOR HOSPITAL AND OTHER MEDICAL EXPENSES

▸ If illness or injury occured while at work, contact the Workers Compensation Insurance Representative, ext. 30807, BEFORE filling out this form.

PART I - TO BE COMPLETED BY STAFF MEMBER OR RETIRED STAFF MEMBER (hereinafter: staff member) OR PATIENT IF COVERED SEPARATE FROM STAFF MEMBER

| 1. Patient's Name (Last, First, M.I.) | 2. Patient's Relationship to Staff Member ☐Self ☐Spouse/DP ☐Child ☐Dependent Parent | 3. Patient's Birthdate Month / Day / Year | 4. Sex ☐M ☐F |
|---|---|---|---|

5. If claim is for son/daughter, was a Dependency (Tax Equivalency) Allowance payable at the time the expense was incurred?
☐Yes ☐No. If No, please answer questions A and B below.

A. Is he/she married? ☐Yes ☐No B. If over 18, is he/she a full time student & dependent upon you for support & maintenance? ☐Yes ☐No

| 6. Staff Member's (or Surviving Spouse's) Name (Last, First, M.I.) *IF NOT PATIENT* | 7. Staff Member's (or Surviving Spouse's) Birthdate *IF NOT PATIENT* | 8. UPI No. |
|---|---|---|

9. Nature of illness, injury or service

| 10. If claim is for accidental injury, enter date and indicate where and how it occurred | 11. Is claim for second surgical opinion? ☐Yes ☐No |
|---|---|

| 12. Is patient, other than staff member, employed? ☐Yes ☐No If Yes, Employee name? | 13. Name and Address of Employer in Item 12. |
|---|---|

14. Is patient covered by another group, student, government (e.g. Medicare) or employment related Medical Plan? ☐Yes ☐No, If Yes, enter:

| Medical Plan Name | Group No. | Name & Address of Carrier |
|---|---|---|

I authorize the release to the World Bank Group Medical Insurance Plan administrator, to the World Bank Group or their representative, any information including medical, employment and benefit information required for claim processing or plan administration. Such information shall be released directly to the World Bank Group only in circumstances where fraud or misconduct is believed to have occurred. This authorization to release information is valid for two years after the date signed. A copy of this authorization shall be as valid as the original. If the staff member is incapacitated or deceased, the Personal Representative or next of kin must sign.

Patient's Signature (Parent/Guardian, if minor; leave blank if staff member) _____ Date _____

I certify that the statements here and attached are complete and accurate. As the patient, I authorize the release of information as described above.

Staff Member's Signature _____ Date _____

PART II - TO BE COMPLETED BY ATTENDING PHYSICIAN (in lieu of itemized bill)

| 15. Physician's Name | 17. Is treatment result of occupational illness or injury? ☐Yes ☐No. If Yes, enter brief description and dates |
|---|---|
| 16. Mailing Address (Street, City, State, ZIP) | 18. Date symptoms first appeared or accident happened? |

| 19. Physician's S.S.N. or T.I.N. | 20. Physician's License No. | 21. Physician's Telephone No. | 22. Date you were first consulted on this condition? |
|---|---|---|---|

23. Diagnosis and current condition

24. Has patient ever had same or similar condition? ☐Yes ☐No, If Yes, indicate when and describe

25. Is patient still under your care for this condition? ☐Yes ☐No

| Date of Service | Place | ICD-9 Code | Description | Charge |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

26. I certify that the procedures as indicated by date have been completed Signature _____ Date _____

**Return completed form to:**
**Aetna/World Bank MIP Claims P.O. Box 14199 Lexington, KY 40512-4199 USA OR via internal mail to MIP claims MSN MC-C3-309.**

Keep a copy of completed form for your records

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