

MEDICAL CLAIM FORM

PART 1: Employee Information

EMPLOYEE NAME (Last and First)	EMPLOYEE DATE OF BIRTH MONTH DAY YEAR	EMPLOYEE SOCIAL SECURITY # — —	GROUP # 4034
EMPLOYEE ADDRESS	CITY	STATE	ZIP
		IS THIS AN ADDRESS CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYEE'S TELEPHONE NUMBER
<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED _____ <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED NAME OF SPOUSE _____			
IF DIVORCED & CLAIM IS FOR DEPENDENT CHILD, ANSWER THE FOLLOWING QUESTIONS: A) IS THIS CHILD IN YOUR PERMANENT CUSTODY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
B) IS THERE A COURT ORDER FOR PROVISION OF MEDICAL CARE FOR THIS CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO			

PART 2: Patient Information

PATIENT NAME	IS PATIENT <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER
MARITAL STATUS	IF OTHER, SPECIFY _____
PATIENT DATE OF BIRTH MONTH DAY YEAR	IF CLAIM IS FOR DEPENDENT OVER AGE 19, IS THE DEPENDENT A FULL TIME STUDENT? IF SO, PLEASE PROVIDE PROOF OF STUDENT STATUS.

PART 3: Description of Claim

DESCRIBE ILLNESS OR INJURY:	WORK RELATED ILLNESS OR INJURY: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DID YOU OR WILL YOU BE FILING A CLAIM WITH L&I? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF CLAIM IS DUE TO ACCIDENT STATE WHEN, WHERE AND HOW THE ACCIDENT OCCURRED:
HAS PATIENT BEEN TREATED FOR THIS ILLNESS OR INJURY WITHIN THE PAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE OF SERVICE: _____	IF YES, NAME AND ADDRESS OF ATTENDING PHYSICIAN REFERRING PHYSICIAN IF APPLICABLE _____	

PART 4: Other Group Health Insurance

ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED BY OTHER INSURANCE FOR MEDICAL, DENTAL, OR VISION BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO CHECK ONLY THOSE COVERED BY OTHER GROUP INSURANCE: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE DATE OF BIRTH _____ <input type="checkbox"/> DEPENDENT(S) LIST THE DEPS. _____ _____ _____	NAME AND ADDRESS OF OTHER INSURANCE CARRIER: POLICY NUMBER: _____ EFFECTIVE DATE: _____
IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ENTER DATE OF ELIGIBILITY _____ SOCIAL SECURITY NO. _____	

PART 5: Complete for all

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING FALSE INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

EMPLOYEE SIGNATURE _____ DATE _____

PART 6: Claims Benefit Assignment and Authorization

SIGNED (BY EMPLOYEE)

I AUTHORIZE PAYMENT OR BENEFITS DIRECTLY TO THE PHYSICIAN OR SUPPLIER: _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION: I expressly authorize any provider of care to furnish HMA, any records concerning me or any Member of my family for whom benefits or services has been claimed. SIGNED (BY PATIENT, OR PARENT, IF MINOR) _____ DATE _____