Mail California claims to:
HealthComp Administators
P.O. Box 45018, Fresno, CA 93718-5018
For questions, call: 855-727-5267

# MEDICAL CLAIM FORM

HealthComp
Third Party Administrators

**Group Name: USC** **Subscriber ID Number: TRJ** ☐☐ - ☐☐☐☐☐☐☐ **Group Number:** S C 1

## PATIENT AND EMPLOYEE INFORMATION

| 1. Patient's Name | 2. Patient's Date of Birth (mm/dd/yyyy) | 3. Employee's Name |
|---|---|---|
| 4. Patient's Address (Street, City, State, Zip Code) | 5. Patient's Gender ☐ Male ☐ Female<br>7. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Registered Domestic Partner | 6. Employee's Address (Street, City, State, Zip Code) ☐ Check here if new address |

8. Other Health Insurance Coverage → Is Patient covered by any other plan (including Medicare)? ☐ Yes ☐ No

If "Yes", provide name and address of carrier: _____

Types of coverage by carrier: ☐ Medical ☐ Drug ☐ Dental ☐ Vision

Identification or Social Security Number: _____

Effective date of other coverage: _____ Termination date of other coverage: _____

| 9. I authorize the undersigned physician to release any information acquired in the course of my examination or treatment. | 10. I authorize payment of medical benefits to the undersigned physician or supplier for service(s) described below. |
|---|---|
| Signed (Patient): Date: | Signed (Patient): Date: |

## PHYSICIAN OR SUPPLIER INFORMATION

| 11. Date of illness (first symptom) or injury (accident) or pregnancy (mm/dd/yyyy) | 12. Date Patient first consulted you for this condition (mm/dd/yyyy) |
|---|---|
| 13. Was condition related to Patient's employment? ☐ Yes ☐ No | 14. Was condition related to an accident? ☐ Yes ☐ No |
| 15. If accident related, please give details: | |
| 16. For services relating to hospitalization, give hospitalization dates | Admitted: / / Discharged: / / |
| 17. Name and address of facility where services rendered: | 18. Was lab or x-ray work performed outside your office? ☐ Yes ☐ No Charges: $ |

19. Diagnosis or nature of illness or injury (relate diagnosis to procedure in Column E below)

20. Place of Service Codes *

| | | | |
|---|---|---|---|
| 1. Inpatient hospital | 5. Day care facility | 9. Ambulance | C. Residential treatment center |
| 2. Outpatient hospital | 6. Night care facility | O. Other location | D. Specialized treatment center |
| 3. Doctor's office | 7. Nursing care | A. Independent lab | E. Comprehensive O/P Rehab |
| 4. Patient's home | 8. Skilled nursing facility | B. Amb. surgery ctr. | F. Ind. Kidney disease treat. ctr. |

| 21. A Date of Service (mm/dd/yyyy) FROM TO | B* Place of Service | C CPT-4 Procedure Code | D Fully describe procedures, medical services or supplies furnished for each date given (explain unusual services or circumstances) | E Diagnosis Code | F Charges | G Days or Units |
|---|---|---|---|---|---|---|
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| 22. Signature of Physician or Supplier (incl. degrees or credentials) Date: | 23. Physician's, supplier's and/or group name, address, zip code and telephone no. | 24. Total Charges: | Balance Due |
|---|---|---|---|
| | | 25. Taxable entity name (if different than Box 23): | |
| 26. Patient's account number: | | 27. Provider's tax identification number: | |