MEDICAL CLAIM FORM

INSTRUCTIONS:

1. **Complete Employees Statement below**
2. **Attach legible itemized bill**
3. **Please refer to your identification card for mailing instructions**

EMPLOYEE'S STATEMENT

NAME OF EMPLOYEE (*First name, middle initial, last name*)	EMPLOYEE'S BIRTH DATE	EMPLOYEE'S ID NUMBER (from medical card)

EMPLOYEE'S ADDRESS (NO.) (STREET) (CITY) (STATE) (ZIP)

EMPLOYEE'S SEX MALE ☐ FEMALE ☐	EMPLOYEE'S MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED	EMPLOYER NAME

IS COVERAGE FOR THIS CLAIM PROVIDED BY ANY OTHER GROUP INSURANCE, FEDERAL PROGRAM (INCLUDING MEDICARE), EMPLOYER, UNION, STUDENT OR ASSOCIATION PLAN? ☐ YES ☐ NO

IF YES, PROVIDE NAME AND ADDRESS OF INSURANCE COMPANY POLICY NUMBER

NAME OF PATIENT	PATIENT'S BIRTH DATE	PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PATIENT'S SEX MALE ☐ FEMALE ☐	IF CLAIM FOR A DEPENDENT CHILD, DO YOU HAVE LEGAL CUSTODY? ☐ YES ☐ NO IS CHILD MARRIED? ☐ YES ☐ NO

DIAGNOSIS, NATURE OF ILLNESS OR INJURY	IS CONDITION RELATED TO EMPLOYMENT? ☐ YES ☐ NO

WAS PATIENT INVOLVED IN AN ACCIDENT? ☐ YES or ☐ NO? IF YES, COMPLETE THE FOLLOWING THREE BOXES / IF NO, SKIP TO ASSIGNMENT

DATE OF ACCIDENT	HOW AND WHERE DID ACCIDENT HAPPEN?

DATE AND NAME & ADDRESS OF PHYSICIAN FIRST CONSULTED

COMPLETE THIS BOX ONLY IF YOU WANT PAYMENT TO GO DIRECTLY TO THE PROVIDER *LEAVE THIS SECTION BLANK FOR PAYMENT TO BE MAILED DIRECTLY TO YOU*

ASSIGNMENT: I AUTHORIZE BENEFITS UNDER THIS CLAIM TO BE PAID DIRECTLY TO THE PROVIDER OF SERVICES PROVIDED THAT THE REQUIRED TAX ID NUMBER HAS BEEN FURNISHED.

DATE:_____ EMPLOYEE'S SIGNATURE: _____

AUTHORIZATION: The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, practitioner or other person, any hospital, including veteran's administration or government hospital, any medical service organization, any insurance company, or other institution, or organization, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other liabilities. A photostat of this authorization shall be as valid as the original.

DATE	EMPLOYEE'S SIGNATURE	PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR)