

### HEALTH CLAIM FORM

**INSTRUCTIONS:** THIS SIDE OF THE FORM MUST BE COMPLETED IN FULL. Attach this form to itemized bills for all expenses being claimed. The bills must show: Patient's Name, Type of Service, Date(s) of Service(s), and the Total Charge. If you are submitting a surgical bill or if the bills are for a major illness, accident, or hospitalization the reverse side of this form must be completed by the attending physician.  
**AVOID DELAY - ANSWER ALL QUESTIONS**

**EMPLOYEE INFORMATION:**

**Employment Status**

Active  Retired  Laid Off  Disability Leave  Other

Employee Name (Please print first name, middle initial, last name)	I.D. Number:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated
Street Address: (street, city, state, zip code)		Date of Birth: Month/Day/Year
Employer's Name:		Group Number:

**DEPENDENT'S INFORMATION: (complete only if patient is a dependent)**

Name of Dependent:	Relationship: <input type="checkbox"/> Other (Explain) _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Child _____
Marital Status (other than spouse):	Date of Birth: Month/Day/Year

**AT TIME CHARGES WERE INCURRED:** (If answer to either is yes, give employer's name and address)

Was spouse employed?  Yes  No      If claim was for child, was child employed?  Yes  No

**COMPLETE FOR ALL PATIENTS:**

Diagnosis or nature of injury:	
When were you first treated for this condition? (month/day/year)	Name and address of physician who first treated you:
<p><b>Is patient also covered for benefits by:</b></p> <p>a. Other Group Health insurance of any kind including Blue Cross and Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Group prepayment arrangement providing for medical care and treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. No fault automobile insurance as a result of injuries sustained in an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If any of the above are answered YES please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency.</b></p>	<p><b>Was illness or injury due in any way:</b></p> <p>a. To the patient's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. To an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. To any other type of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If any of above are answered "Yes" give details under "Accident."</b></p>
<b>Remarks:</b>	
<b>Accident:</b>	
Date: _____ (Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.)	(Place of accident: <input type="checkbox"/> Work <input type="checkbox"/> Other)
How did accident happen?	Name and address where accident occurred:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits to Physician or supplier for services described within.

**SIGNED (PATIENT, OR PARENT IF MINOR)**

► \_\_\_\_\_ Date \_\_\_\_\_

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information necessary to process this claim.

**SIGNED (PATIENT, OR PARENT IF MINOR)**

► \_\_\_\_\_ Date \_\_\_\_\_

