Health Insurance Claim Form

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME *(First name, middle initial, last name)*

4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*

5. PATIENT'S GENDER
MALE ☐ ☐ FEMALE

6. INSURED'S I.D. NO.

7. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. *(Or Group Name)*

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES ☐ ☐ NO
B. AN AUTO ACCIDENT
YES ☐ ☐ NO

11. INSURED'S ADDRESS *(Street, city, state, ZIP code)*

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I AUTHORIZE THE RELEASE O ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM
I declare and certify that the foregoing statements made by me are true to the best of my knowledge and belief. I am aware that if any of the statements made by me are willfully false I may be subject to criminal and civil penalties

SIGNED *DATE*

13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW*

SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES ☐ ☐ NO

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ☐ ☐ NO

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE
1
2
3

☐ Check here if for Second Surgical Opinion

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER

26. YOUR SOCIAL SECURITY NO.

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

SIGNED DATE

30. YOUR EMPLOYER ID NO.

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & *TELEPHONE NO.*

32. ARE YOU BOARD CERTIFIED? ☐ YES ☐ NO

33. YOUR PATIENT'S ACCOUNT NO.

34. SPECIALTY

I.D. NO.

* PLACE OF SERVICE CODES

1 — (IH) — INPATIENT HOSPITAL
2 — (OH) — OUTPATIENT HOSPITAL
3 — (O) — DOCTOR'S OFFICE
4 — (H) — PATIENT'S HOME
5 — DAY CARE FACILITY (PSY)
6 — NIGHT CARE FACILITY (PSY)
7 — FREE STANDING SURGICAL CTR
8 — (SNF) — SKILLED NURSING FACILITY
9 — AMBULANCE
O — (OL) — OTHER LOCATIONS
A — (IL) — INDEPENDENT LABORATORY
B — IMMEDIATE CARE CENTER