

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	EMPLOYEE'S TELEPHONE NUMBER
				IS THIS AN ADDRESS CHANGE? YES NO		
SINGLE		MARRIED _____		WIDOWED		LEGALLY SEPARATED
		NAME OF SPOUSE _____				DIVORCED
IF DIVORCED & CLAIM IS FOR DEPENDENT CHILD, ANSWER THE FOLLOWING QUESTIONS: A) IS THIS CHILD IN YOUR PERMANENT CUSTODY? YES NO						
B) IS THERE A COURT ORDER FOR PROVISION OF MEDICAL CARE FOR THIS CHILD? YES NO						

PART 2: Patient Information

PATIENT NAME		IS PATIENT EMPLOYEE SPOUSE CHILD 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: YES NO IF YES, DID YOU OR WILL YOU BE FILING A CLAIM WITH L&I? YES 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? YES NO CHECK ONLY THOSE COVERED BY OTHER GROUP INSURANCE: SELF SPOUSE DATE OF BIRTH _____ DEPENDENT(S) LIST THE DEPS. _____ _____	NAME AND ADDRESS OF OTHER INSURANCE CARRIER: POLICY NUMBER: _____ EFFECTIVE DATE: _____
IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS? YES 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 _____