Medical Claim Form

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

Section 1. PATIENT INFORMATION

Name (last, first, initial)			Sex	Employer Name	
Home Address			Driver's License Number	Birthdate	Policy Number
City	State	Zip Code	Work Telephone ( )	Home Telephone ( )	

Section 2. ABOUT THIS CLAIM

☐ **Injury** ☐ **Illness** Date and time of accident:	**Describe injury, when and how it happened or nature of illness:**

Was this injury the result of an accident? ☐ **Yes** ☐ **No**

If auto insurance was involved, please provide:	**Policy #**	**Name of insurance company**	**Address (city, state, zip)**

Was this a work-related injury? ☐ **Yes** ☐ **No**

PATIENT'S (or adult dependent's) SIGNATURE REQUIRED

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature: **Date:**

ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)

I authorize payment of benefits to the doctor or supplier of services listed here.

Provider to be paid	Patient's Signature

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill.

A	**Patient Name (last, first, initial)**	**Birthdate**
B	**Address**	
C	**Is this condition the result of an injury arising from patient's employment?** ☐ **Yes** ☐ **No** ***If yes, please contact the Worker's Compensation Carrier/Administrator for proper instruction regarding this claim.***	
D	**Pregnancy?** ☐ **Yes** ☐ **No**	**If yes, expected date of delivery**
E	**If illness, date of first treatment**	**If treating injury, date of injury**
F	**Name of referring physician**	**Referring physician's address**
G	**Name and facility where services were rendered (if other than home or office)**	
H	**Was laboratory work performed outside your office?** ☐ **Yes** ☐ **No**	
I	**For service related to hospitalization, give dates:** ☐ **Admitted** ☐ **Discharged**	

J

Diagnosis and current conditions

1.
2.
3.
4.

K

Dates of Service From To	Places of Services**	Procedure Code (If other than CPT*** code used, give name)	Description of surgical or medical services rendered	Diagnosis Code	Charges

*ICD-10 * International Classification of Disease
*** CPT Current Procedural Terminology (current edition)

**Abbreviations: 11-Physician's Office 12-Inpatient Hospital 23- Emergency Room 12-Patient's Home 22-Outpatient Hospital 81-Independent Laboratory

Date	Physician's Name (print)	Degree	Provider's ID Number
			Must be furnished under authority of law

Physician's Signature	Telephone
	( )

Street Address	City	State	Zip Code

ADDITIONAL NOTES: