Medical Claim Form

Member Information *(please print)*			
Last Name	First	MI	Subcriber ID Number

Patient Information – Complete this section only if claim is for a qualified dependent.			
Last Name	First		MI
Patient ID	Date of Birth	Relationship	Sex

Accident Information – Complete this section only if claim is result of accident or work-related illness or		
Date of accident or first symptoms of illness?	Where did the accident occur? (City/State)	Is accident/illness related to employment? If no, ☐ Auto ☐ Other
Describe the accident or illness.	Give date patient first consulted physician.	Has patient ever had same or similar symptoms? ☐ Yes ☐ No

Medicare Information – Complete this section only if patient is eligible for Medicare.			
Please attach copy of the "Explanation of Benefits" statement from your Medicare insurance carrier.	Medicare Number (include any alpha characters)	Effective Date Part A	Effective Date Part B

Other Health Insurance – If Yes, complete section below or claim cannot be processed. ☐ No other coverage			
Name of Policyholder	Policy Number	Name of Insurance Company/Phone	
Number Street Address	City	State	ZIP

Authorization/Release of Information

I authorize any insurance company, organization, employer, hospital physician, pharmacist or other health care provider to release any information requested with regard to this claim and the expenses reported. I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to omit facts I know are important.

Patient or authorized person's signature _____ Date _____

Assignment of Benefits

I agree to assign benefits directly to the provider of services: _____ Date _____

Patient or authorized person's signature

THIS SECTION FOR PHYSICIAN OR SUPPLIER ONLY. If a detailed statement is available, please attach.

Provider Statement of Services Rendered

Name and address of facility where services were rendered (if other than home or office)	Date Admitted	Date Discharged

Diagnosis Code and Description
1. 3.
2. 4.

Date of Service (from/to)	Place of Service	CPT-4 Procedure Code	Description of Service	Charges	Days or Units	
Signature of Provider				Total Charge	Amount Paid	Balance Due

Provider Name	Tax ID Number
Provider Address	Telephone Number ( )