## PHYSICIAN or PROVIDER: Complete This Section

Diagnosis or Nature of Illness or Injury - Relate diagnosis to procedure in Column D by reference to numbers 1, 2, 3, etc. or ICD-9 Code.

1.
2.
3.
4.

| DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) | DATE FIRST CONSULTED FOR THIS CONDITION | HOSPITAL CONFINEMENT DATES FROM TO |
|---|---|---|
| | | |

| DATE ABLE TO RETURN TO WORK | TOTAL DISABILITY DATES FROM TO | PARTIAL DISABILITY DATES FROM TO |
|---|---|---|
| | | |

NAME AND ADDRESS OF REFERRING PHYSICIAN OR OTHER SOURCE

| A. DATE OF SERVICE | B. PLACE OF SERVICE * | C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (CPT-4: ) (Explain unusual services or circumstances) | D. ICD-9 DIAGNOSIS CODE | E. CHARGES |
|---|---|---|---|---|
| | IH | | | |
| | IH | | | |
| | IH | | | |

| YOUR PATIENT'S ACCOUNT NO. | PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING. TAX I.D. # / SOC. SEC. # | PHYSICIAN OR PROVIDER'S NAME AND ADDRESS / PHYSICIAN'S OR PROVIDER'S TELEPHONE NUMBER ( ) | TOTAL CHARGE $0.00 / AMOUNT PAID / BALANCE DUE |
|---|---|---|---|

**I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.** PHYSICIAN'S OR PROVIDER'S SIGNATURE — DATE

* 1. (IH) - Inpatient Hospital; 2. (OH) - Outpatient Hospital; 3. (O) - Doctor's Office; 4. (H) - Patient's Home; 5. (PSY) - Day Care Facility; 6. (PSY) - Night Care Facility; 7. (NH) - Nursing Home; 8. (SNF) - Skilled Nursing Facility; 9. Ambulance; O. (OL) - Other Locations; A. (IL) - Independent Laboratory; B. Other Medical Facility

## INSTRUCTIONS FOR FILING A CLAIM

**Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.**

YOU SHOULD SUBMIT YOUR CLAIMS MONTHLY OR WHEN YOU HAVE BILLS TOTALING MORE THAN $200.00; BUT YOU MUST USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY.

**1. IMPORTANT**

- A completed claim form must be included with each submission for each member of the family for each separate accident or illness.
- Your claim cannot be processed without your Social Security Number (Employee Section, Block E).
- You must sign and date your claim form (Employee's / Patient's Signature and Release Section).

**2. ATTENDING PHYSICIAN OR PROVIDER INFORMATION SECTION SHOULD BE COMPLETED FOR . . .**

Surgery Doctor's Visits Mental Illness Expenses Hospital Confinement

*Be certain to include procedure code and ICD-9 Diagnosis Code (Physician or Provider Section, blocks C and D).*

**3. IF ENCLOSING ITEMIZED BILLS, THEY MUST INCLUDE:**

| ALL BILLS | | DRUG BILLS *(Please tape to an 8 1/2" x 11" piece of paper)* | |
|---|---|---|---|
| Employee Name | Date of Service | Patient Name | Prescription Date |
| Patient Name | Diagnosis | Physician Name | Drug Name |
| Type of Service | Charge for Service | Prescription Number | Charge |

- Be certain to include Physician or Tax Identification number.
- Bills will not be returned to you - make copies for your records.
- Receipts, balance due statements and cancelled checks are not acceptable.

**4. ADDITIONAL INFORMATION**

Save your Explanation of Benefits - duplicate vouchers are not available.
Second Opinion Surgical Program - Call your benefits counselor for details.

**5. MAILING INSTRUCTIONS**

Send your ***completed claim form*** and itemized bills to the address indicated on the front of this form.