# MEDICAL CLAIM FORM

## Please Fill Out One Form Per Patient

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| **1.** Complete All Questions In Sections A B C & D | **A.** Employer Information | Employer Name | Group Number as Shown on your ID Card |
| | **B.** Employee Information | Employee's Last Name / First Name / Middle Initial | Employee's Social Security Number<br>___-__-____ |
| | ☐ *Check if New Address* | Home Address | Employee's Birth Date |
| | | City / State / Zip Code | |
| | | Marital Status: ☐ Married ☐ Unmarried **Employee's Daytime Telephone** ( ) | |
| | **C.** Patient Information | Patient's Last Name / First Name / Middle Initial | Relationship to Employee<br>☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Stepchild** |
| | | Patient's Birth Date | If over 19, is child a full time student?<br>☐ **Yes** ☐ **No**<br>If yes, school attended: |
| | **D.** Other Group Health Plan Information | Spouse's Birth Date / Is Spouse employed? ☐ Yes ☐ No<br>Employer Name ________ | If yes, does Spouse have health Coverage thru employer ☐ Yes ... Single ☐ or ☐ No Family ☐ |
| | | Is Patient covered by any other Group Health Plan? ☐ Yes ☐ No | If yes, ***COMPLETE THIS SECTION TO EXPEDITE YOUR CLAIM***<br>If no, proceed to Section 2. |
| | | Other Group Plan Name | Identification / Policy No. |
| | | Insurance Company Name and Address | |
| | | City / State / Zip Code | |
| **2.** Complete the sections which apply to your claim | **E.** Accident or Work Related Injury Information | Is this claim due to an accident? ☐ Yes ☐ No<br>If yes, where did the accident occur? ________ | Date of Accident |
| | | Describe accident: | Is this claim the result of a work-related illness or injury?<br>☐ Yes ☐ No |
| **3.** Complete for Assignment of Benefits | **F.** Direct Payment Authorization | I authorize payment to be made directly to the Doctor, Hospital or other medical service provider.<br>☐ Yes ☐ No | |
| **4.** ***MUST*** be signed and dated by Employee | **G.** Authorization To Release Medical and Insurance Information | To any physician, medical practitioner, hospital, clinic or other medically related facility or provider of medical services or supplies and any employer, group policyholder, or contract holder or insurer, I authorize you to release to Associated Benefits Corporation or to its representatives any and all information you may have about the mental and physical history, condition and treatment, and insurance coverage for the Patient named in Section C above.<br><br>I understand the information obtained by Associated Benefits Corporation will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by Associated Benefits Corporation to any person or organization EXCEPT to reinsuring companies, Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year. I know that I may request a copy of this authorization. If this authorization is given in connection with a claim for health benefit, disability or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.<br><br>I verify the above information is true and accurate. | |
| | | **Employee's Signature** | **Date** |
| **5.** | **ATTACH THE BILLS FOR THE MEDICAL EXPENSES YOU ARE CLAIMING. THE BILLS MUST BE ITEMIZED AND SHOW THE PATIENT'S NAME, DIAGNOSIS, TYPE OR TREATMENT AND DATE OF SERVICE.** | | |

Mail claim form to the address on the back of your Insurance Card