REFER TO YOUR I.D. CARD FOR PROPER MAILING ADDRESS

Member Health Care ID Number (HCID)

____

MEDICAL CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION

1. PATIENT'S NAME
2. PATIENT'S DATE OF BIRTH
3. EMPLOYEE'S NAME
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
5. PATIENT'S SEX — MALE ☐ FEMALE ☐
6. EMPLOYEE'S ADDRESS (STREET, CITY, STATE, ZIP CODE) — ☐ CHECK HERE IF NEW ADDRESS
7. PATIENT'S RELATIONSHIP TO EMPLOYEE — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. OTHER HEALTH INSURANCE COVERAGE
   IS PATIENT COVERED BY ANY OTHER PLAN? ☐ YES ☐ NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER:

   IDENTIFICATION NUMBER ______ NAME OF EMPLOYER ______

   TYPES OF COVERAGE BY CARRIER: ☐ MEDICAL ☐ DRUG ☐ DENTAL ☐ VISION

   EFFECTIVE DATE OF COVERAGE ______ TERMINATION DATE OF COVERAGE ______
9. I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

   SIGNED (EMPLOYEE OR PATIENT) ______ DATE ______
10. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW.

    SIGNED (EMPLOYEE OR PATIENT) ______ DATE ______

PHYSICIAN OR SUPPLIER INFORMATION

11. DATE OF ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
12. DATE FIRST CONSULTED YOU FOR THIS CONDITION
13. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT ☐ YES ☐ NO
14. WAS CONDITION RELATED TO ACCIDENT? ☐ YES ☐ NO IF ACCIDENT RELATED, PLEASE GIVE DETAILS:
15. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE AND ADDRESS
16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES — ADMITTED | DISCHARGED
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
18. WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D

PLACE OF SERVICE CODES*

1 - INPATIENT HOSPITAL
2 - OUTPATIENT HOSPITAL
3 - DOCTOR'S OFFICE
4 - PATIENT'S HOME
5 - DAY CARE FACILITY(PSY)
6 - NIGHT CARE FACILITY(PSY)
7 - NURSING CARE
8 - SKILLED NURSING FAC
9 - AMBULANCE
O - OTHER LOCATION
A - INDEPENDENT LAB
B - AMB SURG CTR
C - RESID TREAT CTR
D - SPECIALIZED TREAT CTR
E - COMP O/P REHAB
F - IND KIDNEY DISEASE TREAT CTR

20. A DATE OF SERVICE FROM	TO	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — CPT-4 PROCEDURE CODE	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS

21. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS)

    DATE:
22. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) ☐ YES ☐ NO
23. TOTAL CHARGES — BALANCE DUE
24. YOUR TAX IDENTIFICATION NUMBER
25. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER
26. YOUR PATIENT'S ACCOUNT NUMBER
27. TAXABLE ENTITY NAME (IF DIFFERENT THAN BOX 25)

FORM NO. 110 REV. 3/13

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