

INSTRUCTIONS FOR COMPLETING CLAIM FORM:

- Complete the Employee's Statement below. Have patient's physician complete Part B or attach itemized bills for expenses. 1.
- 2. If you are sending several claims together on the same patient, only one claim form is necessary.

PART A

| SECTION 1 Name of Employee | Nan | ne of Em | ployer | | |
|---|--------------------|------------|-------------|------------------|-------------------|
| Member ID | Date of Birth | / | / | Male Female | Married Single |
| Daytime Phone No | | _ Hom | e Phone No. | | |
| Address of Employee | (C | ity, State | e, and Zip) | | |
| SECTION 2 Claim is made for (check one) Employee | Spouse | | Unmarried | d child under 19 |) |
| Unmarried Student (19-24 Yrs.) attending: (Na | ame of School) | | | | |
| Address of School | | | | | |
| Name of Patient | Date of Bin | th | _//_ | Fe | emale Male |
| Condition Being Treated for: | | | | | |
| IF CLAIM IS FOR AN ACCIDENT PLEA | SE COMPLETE A | ALL QU | ESTIONS I | BELOW: | |
| Was the accident/injury due to insured person? | 's occupation? Yes | s | No | | |
| Date the accident occurred// | Time of Ac | cident _ | | | |
| Where did the accident occur? (address or loca | ation) | | | | |
| Describe the accident in detail | | | | | |
| | | | | | |
| SECTION 3 Is claimant entitled to additional benefits unde If Yes Please Complete in Full: Name, Addres | | | | | |
| Group Policy or Plan No. | | | Spouse's S | ocial Security 1 | No |
| Spouse's Employer | | | Spo | ouse's Date of I | Birth// |

PLEASE SEE RESERVE SIDE FOR AUTHORIZATIONS AND PART B

AUTHORIZATION TO RELEASE INFORMATION

I hereby certify that the foregoing statements, including any accompanying statements are true and complete to the best of my knowledge. I hereby authorize any physician, hospital, insurance company, organization, or employer to release any information including full copies of their records to EMPLOYEE GROUP SERVICES, LTD. for any medical treatment, services, or benefits rendered or payable to me (or my dependents), including information relating to treatment of drug, alcohol, psychiatric disorders, or acquired immune deficiency syndrome (AIDS). This authorization is valid from the date signed for the duration of the claim. I agree that a photocopy of this authorization shall be considered as valid as the original.

| | // | |
|-------------------------|--|--------|
| (Signature of Employee) | (Signature of Patient, if other than Employee) | (Date) |

AUTHORIZATION TO PAY BENEFITS

I hereby authorize payment by my medical plan directly to the undersigned physician or supplier of the medical services, for medical benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

Employee's Signature:

PART B

| 14 DATE OF LLNES (ACTION OR NUMERY (ACCIDENT) OR PREGRAMACY (LMP) 19 DATE INST CONSULTED YOU FOR THIS CONDITION 10 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? 17 DATE PATIENT ABLE TO MERCINANCY (LMP) 10 DATES OF TOTAL DISABILITY FROM DATES OF PATIAL DISABILITY HROUGH DATES OF PATIAL DISABILITY FROM DATES OF PATILIZATION DATES ADATE TO INCOMPT ALIZATION DATES ADATE TO INCOMPT ALIZATION DATES DISCHARGED DISCHARGED DISCHARGED DISCHARGED DISCHARGED DISCHARGED DISCHARGED DISCHARGED INCOMPT ALIZATION DATES ADATE TO INCOMPT ALIZATION DATES PURISHED FOR PARCHDARE NONE oF ORDER IN COLUMN D BY PREFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE DISCHARGED 24 A B C PULL Y DESCHARE PROCEDURES, MEDICAL SERVICES OR DIRCUMPT AND ES DIADATES DIADATES DIADATES DIADATES DIADATES DIADATES DIADATES DIADATES | Pł | PHYSICIAN OR SUPPLIER INFORMATION | | | | | | | | | | | | | | | | |
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PLACE OF SERVICE CODES

1 - (IH) - INPATIENT HOSPITAL

2 - (OH) - OUTPATIENT HOSPITAL

3 - (0) - DOCTOR'S OFFICE

4 - (H) - PATIENT'S HOME

5 -DAY CARE FACILITY (PSY) NIGHT CARE FACILITY (PSY) 6 -

7 - (NH) - NURSING HOME

9 -

8 - (SNF) - SKILLED NURSING FACILITY AMBULANCE

O - (OL) - OTHER LOCATIONS A - (IL) - INDEPENDENT LABORATORY

3 -OTHER MEDICAL/SURGICAL FACILITY