PO Box 75008
Cedar Rapids, Iowa 52407-5008
(319) 398-3283
(800) 475-2232

INSTRUCTIONS FOR COMPLETING CLAIM FORM:

1. Complete the Employee's Statement below. Have patient's physician complete Part B or attach itemized bills for expenses.
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 ________________________________ Name of Employer ________________________________

Member ID ____________________________ Date of Birth ______/______/_______ Male _____ Female _____ Married _____ Single _____

Daytime Phone No. ______________________________________ Home Phone No. ______________________________________

Address of Employee ____
(City, State, and Zip)

SECTION 2

Claim is made for (check one) Employee _____ Spouse _____ Unmarried child under 19 _____

Unmarried Student (19-24 Yrs.) attending: (Name of School) ____

Address of School ____

Name of Patient ______________________________ Date of Birth ______/______/_______ Female _____ Male _____

Condition Being Treated for:____

IF CLAIM IS FOR AN ACCIDENT PLEASE COMPLETE ALL QUESTIONS BELOW:

Was the accident/injury due to insured person's occupation? Yes _____ No _____

Date the accident occurred ______/______/_______ Time of Accident _______________

Where did the accident occur? (address or location) ____

Describe the accident in detail ____

____

SECTION 3

Is claimant entitled to additional benefits under any other Group Health Insurance or Medicare? Yes _____ No _____

If Yes Please Complete in Full: Name, Address, and Phone Number of Other Insurance Company: ___________________________

____

Group Policy or Plan No. ____ Spouse's Social Security No. ______________________

Spouse's Employer ____ Spouse's Date of 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

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ ☐ NO
17 DATE PATIENT ABLE TO RETURN TO WORK	18 DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM / THROUGH
19 NAME OF REFERRING PHYSICIAN			20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED / DISCHARGED
21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*			22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES

23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY PREFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

24 A DATE OF SERVICE	B PLACE OF SERVICE	C PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES, OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F

25 SIGNATURE OF PHYSICIAN OR SUPPLIER *SIGNED* DATE	26 ACCEPT ASSIGNMENT YES ☐ ☐ NO	27 TOTAL CHARGE	28 AMOUNT PAID	29 BALANCE DUE
	30 YOUR SOCIAL SECURITY NO	31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE, & *TELEPHONE NO*		
32 YOUR PATIENT'S ACCOUNT NO	33 YOUR EMPLOYER I.D. NO	I.D. NO		

· PLACE OF SERVICE CODES

- 1 - (IH) - INPATIENT HOSPITAL
- 2 - (OH) - OUTPATIENT HOSPITAL
- 3 - (O) - DOCTOR'S OFFICE
- 4 - (H) - PATIENT'S HOME
- 5 - DAY CARE FACILITY (PSY)
- 6 - NIGHT CARE FACILITY (PSY)
- 7 - (NH) - NURSING HOME
- 8 - (SNF) - SKILLED NURSING FACILITY
- 9 - AMBULANCE
- O - (OL) - OTHER LOCATIONS
- A - (IL) - INDEPENDENT LABORATORY
- 3 - OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74