


MEDICAL CLAIMS ADMINISTERED BY 

PART A - MEMBER STATEMENT - Failure to Answer All Questions May Delay Payment

1. Member's Name		Street Address		City or Town		ZIP Code	
2. Plan Number		Social Security #		Are you still employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, enter date last worked	
3. Date of Birth		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		Name of Your Employer		Occupation	
4. Spouse's Date of Birth		Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, enter the name and address of spouse's employer			
5. Are you or your dependents covered under another group insurance or government plan such as Medicare, an HMO or automobile no fault coverage, which will also cover any of the medical expenses on the claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, enter name and address: Policy # / ID #: Family Member Holding Policy:			
6. Is claim for a dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, enter dependent name (first, last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	Relationship to Member
6a. If child, is he/she married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is child over 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, enter name of school	
7. Is claim for an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date: Time:		Where did it occur?		While working? <input type="checkbox"/> Yes <input type="checkbox"/> No	How did it occur?
8. SIGN HERE IF YOU WANT BENEFITS PAID TO DOCTOR/HOSPITAL							DATE:
9. SIGN HERE FOR ALL CLAIMS							DATE:

I hereby authorize any insurance company, hospital, or physician to release all information which may have a bearing on benefits payable under this plan of benefits.

PART B - DOCTOR OR SUPPLIER - Complete and Return to Patient

Patient's Name		Date of Birth	Date first consulted for condition		Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Referring Physician		
Date patient able to return to work		Dates of total disability From Through		Dates of partial disability From Through					
Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column D by reference to numbers 1, 2, 3, etc. or DX Code							Is condition related to work incurred injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
1.	2.	3.	4.						
A Date of Service	B Place of Service	C Describe fully procedures, medical services, or supplies furnished for each date given Procedure Code (Identify:) (Explain unusual Services or Circumstances)			D DX Code (ID:)	E Charges			
Signature of Physician	SIGNED	Date:	Total Charges	Amount Paid	Balance Due				
Provider's Social Security # / Tax ID #		Physician's Name, Address, ZIP Code					Telephone (include Area Code)		

- Place of Service Codes**
- | | | | |
|-------------------------------|--------------------------------|-------------------------------------|---------------------------------------|
| 1. (H) - Inpatient Hospital | 4. (H) - Patient's Home | 7. (NH) - Nursing Home | 10. (OL) - |
| 2. (OH) - Outpatient Hospital | 5. - Day Care Facility | 8. (SNF) - Skilled Nursing Facility | 11. (IL) - Independent Laboratory |
| 3. (O) - Doctor's Office | 6. - Night Care Facility (PSY) | 9. - Ambulance | 12. - Other Medical/Surgical Facility |

- Group Medical Claim - HOW TO FILE A CLAIM**
- | | |
|---|---|
| <p>Member</p> <ol style="list-style-type: none"> Complete Part A - One for each family member If claim is for a dependent, also complete lines 6 & 6a If claim is for an accident, complete line 7 For all claims, sign line 9 If you want benefits paid to doctor/hospital, sign form on line 8 Enclose a copy of other carriers' payment worksheet when you have other insurance. Ask your doctor to provide itemized bills with diagnosis for care | <p>Doctor/Dispenser</p> <ol style="list-style-type: none"> Complete Part B Or, attach itemized Bill which includes Diagnosis for care Sign form - return to patient |
|---|---|

Forward Completed Claim Forms To:
P.O. Box 11111
Fort Scott, KS 66701

NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against a claims administrator or payer, submits an application or files a claim containing a false or deceptive statement is guilty of fraud. Such action is considered to be a felony in some states.