GROUP HEALTH CLAIM FORM

INSTRUCTIONS

- Use this form when submitting bills for medical claims.
- Be sure bills are itemized. Attach bills to this form.
- Give accurate information to items below. This will help us give you faster claim service.

- **USE ONE FORM PER PATIENT**

1

NAME OF EMPLOYEE:	DATE OF BIRTH:	MO.	DAY	YR.	PATIENT NAME	DATE OF BIRTH	MO.	DAY	YR.	RELATIONSHIP ( ) SELF ( ) SPOUSE ( ) CHILD

ADDRESS:

SOCIAL SECURITY NUMBER	STATUS ☐ ACTIVE ☐ RETIRED ☐ COBRA	EMPLOYER/GROUP NAME	GROUP POLICY NUMBER

NAME OF SPOUSE:	DATE OF BIRTH:	MO.	DAY	YR.	SPOUSE'S EMPLOYER

IF PATIENT IS CHILD OVER AGE 18, IS CHILD A FULL-TIME STUDENT? ☐ YES ☐ NO NUMBER OF CREDIT HOURS_____ PLEASE SEND PROOF OF CURRENT CLASS REGISTRATION

IF YES, NAME AND ADDRESS OF SCHOOL _____

IS CHILD MARRIED? ☐ NO ☐ YES MARRIAGE DATE _____

2

IN ADDITION TO COVERAGE UNDER THIS PROGRAM IS PATIENT COVERED UNDER ANY OTHER INSURANCE PLAN? ☐ NO ☐ YES

IF YES, IS IT ☐ GROUP ☐ INDIVIDUAL

Name of Policy Holder_____ Relationship to Patient _____

Name and Address of Policy Holder's Employer _____

Name, Address and Telephone # of other Insuring Company_____

_____

Policy # _____ Effective Date of Coverage _____

Type of Coverage ☐ Medical ☐ Dental ☐ Other

3

THIS CLAIM IS DUE TO: (COMPLETE ONE OF THESE SECTIONS)

☐ AN INJURY_____ DATE OF INJURY _____ WHERE DID IT OCCUR? _____

HOW DID IT HAPPEN? _____

WHEN DID PATIENT FIRST SEE A DOCTOR? _____

WAS THE INJURY CONNECTED WITH THE PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

☐ A SICKNESS

WHEN DID SYMPTOMS BEGIN? _____ WHEN DID PATIENT FIRST SEE A DOCTOR? _____

NAME AND ADDRESS OF DOCTOR _____

4

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN(S) OR SUPPLIER(S) FOR SERVICES PER ATTACHED BILLS.

_____ _____

SIGNATURE OF EMPLOYEE DATE

5

I CERTIFY THE ABOVE COMPLETE AND CORRECT AND THAT I AM CLAIMING BENEFITS ONLY FOR CHARGES INCURRED BY THE PATIENT NAMED ABOVE.

I AUTHORIZE ANY HOSPITAL, PHYSICIAN, OR OTHER PROVIDER TO RELEASE INFORMATION WHICH MAY BE NECESSARY TO DETERMINE BENEFITS PAYABLE UNDER THE PLAN. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____ _____

SIGNATURE OF EMPLOYEE DATE

MAIL BILLINGS AND COMPLETED CLAIM FORMS TO:
EMPLOYEE PLANS, INC.
1111 CHESTNUT HILLS PARKWAY
FT. WAYNE, IN 46814

EPI-27