



Medical Claim Form

Return this form to: **Group Administrators, Ltd.**
 953 American Lane, Suite 100
 Schaumburg, IL 60173
 Fax: (847) 519-1979

Section 1 – Member’s Statement *Please Print (Attach All Bills).*

<i>Member’s Social Security No.</i>		<i>Member’s Full Name</i>			<i>Member’s Birth Date</i>	<i>Mo.</i>	<i>Day</i>	<i>Yr.</i>	<i>Sex</i>
<i>If address has changed since last claim place “X” in this box</i> <input type="checkbox"/>	<i>Member’s Street Address</i>		<i>Member’s City & State</i>		<i>Zip Code</i>				
<i>Occupation</i>					<i>Member’s Home Phone Number</i>				
<i>If this claim is for a dependent, also fill out this part</i>	<i>Relationship of Dependent</i>		<i>Dependent’s First Name & Initial</i>			<i>Dependent Birth Date</i>			
						<i>Mo.</i>	<i>Day</i>	<i>Yr.</i>	<i>Age</i>
<i>These questions must be answered</i>		<i>Is your spouse employed?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>Is patient covered by any other group insurance or Medicare?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If either answer is yes Section 2 must be completed</i>			
<i>Was the disability due to an accident or occupational illness?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Did it occur on the job?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Date occurred?</i>	<i>Where did accident occur?</i>		<i>How did it occur?</i>				

ASSIGNMENT OF BENEFITS:

Do you want us to pay your doctor directly? Yes No

The statements on this form are true and correct to the best of my knowledge.

NOTICE: It is illegal to file a false or fraudulent claim or to knowingly help someone else file one. You may be fined or sent to prison for doing so. You may also be required to pay civil damages.

<i>Employee’s Signature</i>	<i>Date</i>
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Section 2 – Coordination of Benefits Information

Spouse’s First Name _____ *Spouse’s SSN* _____ *Policy Number* _____ *Group Number* _____ *Effective Date* _____

Name of Spouse’s Employer _____ *Insurance Company/Claims Paying Office (CPO)* _____

Address of Spouse’s Employer _____ *Address of Insurance Company (CPO)* _____

City, State & Zip Code _____ *City, State, Zip Code of Insurance Co./CPO* _____

The authorization for release of information must be completed on the reverse side of this form.

Authorization for Release Information

I **AUTHORIZE** any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to Group Administrators, Ltd. or its legal representative, any and all such information.

I **UNDERSTAND** the information obtained by use of the Authorization will be used by Group Administrators, Ltd. or its authorized claims paying administrator to determine eligibility for benefits or services under a policy. Any information obtained will not be released by Group Administrators, Ltd. to any person or organization **EXCEPT** to reinsuring companies, the Medical Information Bureau, Inc., employer, group policyholder, contractholder, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I **KNOW** that I may request to receive a copy of this Authorization. I **AGREE** that a photographic copy of this Authorization shall be as valid as the original. I **AGREE** this Authorization shall be valid for two and one half years from the date shown below.

Employee's Signature _____	Date _____	Patient's Signature (if other than a minor child) _____	Date _____
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Patient & Employee Information					
Patient's Name (First name, middle initial, last name)				Patient's Date of Birth	
Employee's Name (First name, middle initial, last name)					
Physician or Supplier Information					
1. Date of	Illness (first symptom) or injury (accident) or Pregnancy (LMP)	2. Date you were first consulted for this condition	3. Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Date patient able to return to work	5. Dates of total disability From _____ Through _____		Date of partial disability From _____ Through _____		
6. Name of referring physician			7. For services related to hospitalization give hospitalization dates Admitted _____ Discharged _____		
8. Name & address of facility where services rendered (if other than home or office)			9. Was laboratory work performed outside your office? <input type="checkbox"/> Yes <input type="checkbox"/> No Charges		
10. Diagnosis or nature of illness or injury. <u>Relate diagnosis to procedure in column D by reference to numbers 1, 2, 3 etc. or DX code</u>					
1. 2. 3. 4.					
11. A Date of Service	B Place of Service	C Fully describe procedures, medical services or supplies furnished for each date given (Explain unusual services or circumstances)	D Diagnosis Code	E Charges	F
		12 Your Social Security No.	13. Total Chg.	14. Amt. Paid	15. Balance Due
16. Signature of physician or supplier			17. Physician's or supplier's name, address, zip code & telephone no.		
18. Your patient's name and account no.		19. Your Employer I.D. No.		I.D. No.	