Medical Claim Form

Return this form to:

Group Administrators, Ltd.
20 North Martingale Rd., Suite 290
Schaumburg, IL 60173
Fax: (855)-978-2331

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

Member's Social Security No.	*Member's Full Name*	Member's Birth Date	*Mo.*	*Day*	*Yr.*	*Sex*

If address has changed since last claim place "X" in this box ☐	*Member's Street Address*	*Member's City & State*	*Zip Code*

Occupation	*Member's Home Phone Number*

If this claim is for a dependent, also fill out this part	*Relationship of Dependent*	*Dependent's First Name & Initial*	*Dependent Birth Date* Mo.	Day	Yr.	Age

These questions must be answered	Is your spouse employed? ☐ Yes ☐ No	Is patient covered by any other group insurance or Medicare? ☐ Yes ☐ No	If either answer is yes Section 2 must be completed

Was the disability due to an accident or occupational illness? ☐ Yes ☐ No	Did it occur on the job? ☐ Yes ☐ No	Date occurred?	Where did accident occur?	How did it occur?

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.

Employee's Signature	*Date*

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*

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? ☐ Yes ☐ 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? ☐ Yes ☐ No Charges

10. 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***

1.
2.
3.
4.

11. A Date of Service	B Place of Service	C Fully describe procedures, medical services or supplies: Procedure Code (Identity) / 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.

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