



1733 Park Street, Suite 300  
 Naperville, IL 60563-0565  
 (630) 416-1111

**MEDICAL CLAIM FORM**

<b>PART 1: Complete for all claims</b>		
EMPLOYEE'S NAME (Last)	(First)	(Middle)
EMPLOYEE'S ADDRESS		EMPLOYEE IDENTIFICATION NO.
AREA CODE & PHONE NUMBER		EMPLOYER
ARE YOU <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		POLICY NUMBER
DO YOU HAVE MORE THAN ONE EMPLOYER IF YES, GIVE NAME AND ADDRESS OF EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO		
THIS CLAIM IS FOR <input type="checkbox"/> MALE EMPLOYEE <input type="checkbox"/> FEMALE EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD	PATIENT'S DATE OF BIRTH	IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO
GIVE NATURE OF ILLNESS OR INJURY	IF CLAIM IS DUE TO ACCIDENT, STATE WHEN, WHERE AND HOW IT OCCURRED	

**PART 2: Complete if you are married or divorced**

NAME OF YOUR SPOUSE OR EX-SPOUSE	DATE OF BIRTH	IS YOUR SPOUSE/EX-SPOUSE EMPLOYED? IF YES, NAME OF THEIR EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO
NAME OF HEALTH BENEFIT CARRIER	IDENTIFICATION #	AREA CODE & PHONE NUMBER
		<input type="checkbox"/> SINGLE COVERAGE <input type="checkbox"/> FAMILY COVERAGE

**PART 3: Complete if for a dependent other than your spouse**

NAME OF DEPENDENT	IF CHILD OVER 19, INDICATE: <input type="checkbox"/> HANDICAPPED <input type="checkbox"/> STUDENT (GIVE NAME & PHONE NUMBER OF SCHOOL) <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME		
IS THIS DEPENDENT EMPLOYED? IF YES, NAME AND ADDRESS OF EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO		EMPLOYER TELEPHONE	
NAME OF DEPENDENT'S GROUP HEALTH BENEFIT CARRIER			
IS THIS DEPENDENT COVERED BY ANY OTHER PERSON'S NOT LISTED ABOVE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME OF HEALTH BENEFIT CARRIER	ID NUMBER	AREA CODE & PHONE NUMBER	
NAME OF INSURED	RELATIONSHIP TO DEPENDENT	DATE OF BIRTH	

**PART 4: Complete for all claims**

I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, pharmacy, clinic or any other organization to release all information with respect to myself or any of my dependents which may have bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information in support of this claim is true and correct. A photostat of this authorization shall be as valid as the original.

DATE \_\_\_\_\_ SIGNATURE OF EMPLOYEE \_\_\_\_\_

DATE \_\_\_\_\_ If claim on spouse signature \_\_\_\_\_