A B A S

AMERICAN BENEFIT ADMINISTRATIVE SERVICES, INC.

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

AMERICAN MEDICAL ACCESS

Association Hospital / Medical Indemnity Plan

MEDICAL CLAIM FORM

PART 1: Complete for all claims

MEMBER'S NAME (Last) (First) (Middle)

MEMBER'S ADDRESS | AREA CODE & PHONE NUMBER

ARE YOU ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

ARE YOU EMPLOYED? ☐ YES ☐ NO | IF YES, GIVE NAME AND ADDRESS OF EMPLOYER | EMPLOYER TELEPHONE

NAME OF HEALTH BENEFIT CARRIER, if applicable | IDENTIFICATION # | AREA CODE & PHONE NUMBER | ☐ SINGLE COVERAGE ☐ FAMILY COVERAGE

THIS CLAIM IS FOR ☐ MALE MEMBER ☐ FEMALE MEMBER ☐ SPOUSE ☐ CHILD | PATIENT'S DATE OF BIRTH | IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS? ☐ YES ☐ 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? ☐ YES ☐ NO IF YES, NAME OF THEIR EMPLOYER

NAME OF HEALTH BENEFIT CARRIER, if applicable | IDENTIFICATION # | AREA CODE & PHONE NUMBER | ☐ SINGLE COVERAGE ☐ FAMILY COVERAGE

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

NAME OF DEPENDENT | IF CHILD OVER 19, INDICATE: ☐ HANDICAPPED ☐ STUDENT (GIVE NAME & PHONE NUMBER OF SCHOOL) ☐ FULL-TIME ☐ PART-TIME

IS THIS DEPENDENT EMPLOYED? IF YES, NAME AND ADDRESS OF EMPLOYER ☐ YES ☐ NO | EMPLOYER TELEPHONE

NAME OF DEPENDENT'S GROUP HEALTH BENEFIT CARRIER, if applicable

IS THIS DEPENDENT COVERED BY ANY OTHER PERSONS NOT LISTED ABOVE? ☐ YES ☐ 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 MEMBER ____

DATE ____________________ If claim on spouse, signature ____