

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

MEDICAL CLAIM FORM

PART 1: Complete for all claims		
EMPLOYEE'S NAME (Last) _____ (First) _____ (Middle) _____	EMPLOYEE IDENTIFICATION NO. _____	
EMPLOYEE'S ADDRESS _____	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 <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME AND ADDRESS OF EMPLOYER _____		
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 _____

Part 5: Assignment of Benefits

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S): I hereby authorize payment directly to the Provider(s) of service for Medical Benefits, if otherwise payable to me for their services. Not to exceed the policy limitations.	Signed (Employee)
	Date _____