



HEALTH CLAIM FORM

PATIENT INFORMATION

1. EMPLOYEE'S SSN		GROUP NUMBER		GROUP NAME	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTHDATE (mm/dd/yr) M <input type="checkbox"/> F <input type="checkbox"/>		4. EMPLOYEE'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)		6. PATIENT RELATIONSHIP TO EMPLOYEE Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. EMPLOYEE'S ADDRESS (No. Street)	
CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ()	Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student <input type="checkbox"/>		ZIP CODE	TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) [] c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO d. PLEASE PROVIDE ACCIDENT DETAILS: _____ _____		11. EMPLOYEE'S POLICY GROUP	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYEE'S DATE OF BIRTH (mm/dd/yr) M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH (mm/dd/yr) M <input type="checkbox"/> F <input type="checkbox"/>				b. CLAIMS ADMINISTRATOR FISERV HEALTH P. O. Box 690450 San Antonio, TX 78269-0450 (800) 769-1452 e-mail address: service@benplan.com or www.benplan.com	
c. EMPLOYER'S NAME OR SCHOOL NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME				c. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (mm/dd/yr)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (mm/dd/yr)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (mm/dd/yr) TO (mm/dd/yr)						
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. I.D. NUMBER OF REFERRING PHYSICIAN		19. HOSPITAL DATES RELATED TO CURRENT SERVICES FROM (mm/dd/yr) TO (mm/dd/yr)						
				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
				23. PRIOR AUTHORIZATION NUMBER						
24. A DATE(S) OF SERVICE From (mm/dd/yr) To (mm/dd/yr)		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstance) CPT HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSOT Family Plan	I EMG	J COB
1										
2										
3										
4										
5										
6										
25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)			33. PHYSICIAN/SUPPLIER BILLING ADDRESS: PIN# _____ GRP# _____					