

HEALTH CLAIM TRANSMITTAL

Employer Name
Group (policy) **Number**

A. SUBSCRIBER/EMPLOYEE INFORMATION

Subscriber # or SSN: — —		Phone #: () ()	
Last Name:	First Name:	MI:	Date of Birth: / /
Home Address:			New Address: Yes <input type="checkbox"/> No <input type="checkbox"/>
City:		State:	Zip Code:
Spouse Last Name:	First Name:	MI:	Spouse Date of Birth: / /

B. PATIENT INFORMATION

Last Name:	First Name:	MI:	Date of Birth: / /
Home Address:			
City:		State:	Zip Code:
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Relationship to Subscriber:	Full Time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	School Name: () ()

C. ACCIDENT INFORMATION

Work Accident: Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto Accident: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Accident Occurred: / /
How did the accident occur?		

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following:	
Name of person carrying other insurance:	Date of Birth: / /
SSN: — —	Name of Other Insurance Carrier:
Policy Number:	Employer Name:
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.	
Subscriber Signature: _____ Date: _____	

E. ASSIGNMENT OF BENEFITS

Please sign below _____ <i>to pay benefits directly to the provider</i> of medical services.	
Subscriber Signature: _____ Date: _____	

GUIDELINES FOR SUBMITTING CLAIMS

- Clip, do not staple, all bills to the completed form and mail them
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Submit all claims
- Be sure to notify your employer of all address changes.
- Please include your Subscriber # or SSN on all documents.