EMPLOYEE GROUP MEDICAL CLAIM FORM

SUBMIT CLAIMS TO:

ASSURECARE®
Assured Access Health Systems Management
340 Quadrangle Drive
Bolingbrook, IL 60440
Phone: (630) 759-1311
Fax: (630) 759-5219

PART A EMPLOYEE INFORMATION *(PARTS A - B - C - TO BE COMPLETED BY EMPLOYEE)*

1) EMPLOYEE NAME (Last, First, Middle)	2) EMPLOYEE SOCIAL SECURITY NUMBER

3) EMPLOYEE ADDRESS	CITY	STATE	ZIP CODE

4) EMPLOYER NAME	5) GROUP #

PART B PATIENT INFORMATION

6) PATIENT NAME (If a Dependent)	7) PATIENT SOC SEC #	8) PATIENT BIRTH DATE	9) PATIENT SEX
			☐ Male ☐ Female

10) PATIENT ADDRESS *(If different from employee)*	MAILING ADDRESS	CITY	STATE	ZIP CODE

11) RELATIONSHIP TO EMPLOYEE	12) WAS CONDITION RELATED TO	IF AN ACCIDENT	DESCRIPTION (DETAILS & ADDRESS)
☐ Spouse ☐ Child ☐ Self ☐ Other	☐ Patient's Employment ☐ An Accident	DATE _____/_____/_____ TIME _____:_____ a.m. / p.m	

PART C OTHER HEALTH COVERAGE

13) DOES EMPLOYEE'S SPOUSE HAVE OTHER HEALTH COVERAGE?	(IF YES) SPOUSE NAME	SPOUSE EMPLOYER	EMPLOYER PHONE #	EMPLOYMENT DATE
☐ Yes ☐ No				

15) DOES PATIENT HAVE OTHER HEALTH COVERAGE?	IF YES, PLEASE IDENTIFY	14) IS PATIENT ENTITLED TO BENEFITS UNDER MEDICARE PART A OR B?
☐ Yes ☐ No		☐ Yes ☐ No EFF DATE ____/____/_____ ID # _____/_____/_____

PART C PHYSICIAN OR SUPPLIER INFORMATION *(TO BE COMPLETED BY PHYSICIAN AND RETURNED TO EMPLOYEE)*

16) DATE OF ILLNESS (First symptom, injury, accident, or pregnancy/LMP)	17) DATE FIRST CONSULTED YOU FOR THIS CONDITION	18) HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
		☐ Yes ☐ No

19) DATE PATIENT ABLE TO RETURN TO WORK	20) DATES OF TOTAL DISABILITY	21) DATES OF PARTIAL DISABILITY
	From: Through	From Through

22) NAME OF REFERRING PHYSICIAN	23) FOR SERVICES RELATED TO HOSPITALIZATION, GIVE DATES
	Admitted Discharged

24) NAME/ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other t han office)*	25) WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE?
	☐ Yes ☐ No

DIAGNOSIS OR NATURE OF ILLNESS / INJURY

ICDA CODE	WRITTEN DIAGNOSIS
1	
2	
3	

DETAILS ☐ HCFA 1500 ATTACHED *(DETAIL SECTION NOT REQUIRED IF HCFA 1500 ATTACHED)*

DATE OF SERVICE	PLACE OF SERVICE*	CPT CODE	PROCEEDURES, MEDICAL SERVICE AND SUPPLIES FURNISHED FOR EACH DATE (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	ICDA DIAGNOSIS CODE	CHARGES	FOR OFFICE USE ONLY

PHYSICIAN/PROVIDER NAME	TAX ID NUMBER / SOCIAL SECURITY #	PHONE	TOTAL CHARGES

MAILING ADDRESS	CITY	STATE	ZIP CODE	AMOUNT PAID	BALANCE DUE

PATIENTS ACCOUNT #	PHYSICIAN/PROVIDER SIGNATURE	DATE
I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN FOR SERVICES DESCRIBED	PATIENT/AUTHORIZED PERSON SIGNATURE	DATE
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.	EMPLOYEE/AUTHORIZED PERSON SIGNATURE	DATE

** PLACE OF SERVICE CODE:*

11-Doctor's Office
12-Patient's Home
13-Inpatient Hospital
22-Outpatient Hospital
23-Emergency Room-Hospital
24-Amb. Surgical Center
34-Hospice
51-Inpatient Psychiatric Facility
82-Independent Laboratory

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