

# EMPLOYEE GROUP MEDICAL CLAIM FORM

SUBMIT CLAIMS TO:



Phone: (800) 328-0927  
Fax: (763) 383-4880

| 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<br><input type="checkbox"/> Male <input type="checkbox"/> Female |                                 |
| 10) PATIENT ADDRESS<br><i>(if different from employee)</i>   |   | MAILING ADDRESS   | CITY STATE ZIP CODE             |
| 11) RELATIONSHIP TO EMPLOYEE<br><input type="checkbox"/> Spouse <input type="checkbox"/> Child<br><input type="checkbox"/> Self <input type="checkbox"/> Other | 12) WAS CONDITION RELATED TO<br><input type="checkbox"/> Patient's Employment<br><input type="checkbox"/> An Accident | IF AN ACCIDENT<br>DATE ____/____/____<br>TIME ____:____ a.m. / p.m              | DESCRIPTION (DETAILS & ADDRESS) |

| PART C OTHER HEALTH COVERAGE   |                         |   |                                  |
|--|-------------------------|---|----------------------------------|
| 13) DOES EMPLOYEE'S SPOUSE HAVE OTHER HEALTH COVERAGE?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | (IF YES) SPOUSE NAME    | SPOUSE EMPLOYER   | EMPLOYER PHONE # EMPLOYMENT DATE |
| 15) DOES PATIENT HAVE OTHER HEALTH COVERAGE?<br><input type="checkbox"/> Yes <input type="checkbox"/> No           | IF YES, PLEASE IDENTIFY | 14) IS PATIENT ENTITLED TO BENEFITS UNDER MEDICARE PART A OR B?<br><input type="checkbox"/> Yes <input type="checkbox"/> 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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |  |
| 19) DATE PATIENT ABLE TO RETURN TO WORK  |  | 20) DATES OF TOTAL DISABILITY<br>From: Through  |  | 21) DATES OF PARTIAL DISABILITY<br>From: Through   |   |  |  |
| 22) NAME OF REFERRING PHYSICIAN  |  |   | 23) FOR SERVICES RELATED TO HOSPITALIZATION, GIVE DATES<br>Admitted Discharged |  |   |  |  |
| 24) NAME/ADDRESS OF FACILITY WHERE SERVICES RENDERED <i>(if other than office)</i> |  |   |  |  | 25) WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |

| DIAGNOSIS OR NATURE OF ILLNESS / INJURY |                   |
|---|-------------------|
| ICDA CODE                               | WRITTEN DIAGNOSIS |
| 1                                       |                   |
| 2                                       |                   |
| 3                                       |                   |

| DETAILS <input type="checkbox"/> 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<br>(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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