

MEDICAL GROUP MEDICAL CLAIM FORM

SUBMIT CLAIMS TO:



Phone: (330) 528-3929
Fax: (330) 342-1642

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

PART C OTHER HEALTH COVERAGE

13) DOES EMPLOYEE'S SPOUSE HAVE OTHER HEALTH COVERAGE? <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? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, PLEASE IDENTIFY	14) IS PATIENT ENTITLED TO BENEFITS UNDER MEDICARE PART A OR B? <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? <input type="checkbox"/> Yes <input type="checkbox"/> No
19) DATE PATIENT ABLE TO RETURN TO WORK	20) DATES OF TOTAL DISABILITY From: Through	21) DATES OF PARTIAL DISABILITY 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 <i>(If other than office)</i>		25) WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> Yes <input type="checkbox"/> 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