STATEMENT OF CLAIM FOR GROUP MEDICAL EXPENSE BENEFITS

GROUP INSURANCE SERVICE CENTER, INC.
P.O. Box 9120, Marshfield, MA 02050-9120

HOW TO FILE A CLAIM: COMPLETE EACH SECTION ON THIS SIDE OF CLAIM FORM HAVE THE ATTENDING PHYSICIAN COMPLETE HIS PORTION OF REVERSE SIDE IF YOU DO NOT HAVE ITEMIZED BILL.

INCOMPLETE ANSWERS MAY DELAY PROCESSING.

FORWARD COMPLETED CLAIM FORMS TO:

Company certifies employee is a member of Group Health Plan.

Signed.....

Effective coverage date of claimant.....

Termination date of coverage.....

NAME AND ADDRESS OF EMPLOYER

.....

.....

.....

ABOUT YOU

Name and Address of Employee: SS#.

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.....

☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Date of Birth

...../...../.....

ABOUT YOUR SPOUSE

Name of Spouse.....

Is Spouse Employed? ☐ Yes ☐ No

Does Spouse's Employer Provide Group Insurance? ☐ Yes ☐ No

Is Your Spouse Covered By That Plan? ☐ Yes ☐ No

Name and Address of Spouse's Employer

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ABOUT THE PATIENT

This Claim is For:

Myself - if disabled, 1st day not worked ...../...../..... Expected Return..../..../.....

My Spouse..... Date of Birth...../...../.....

My Child ..... Date of Birth...../...../.....

Is Child Employed? ☐ Yes ☐ No

Employer or School Name, City, State

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If over 19 years of age, is child a full-time Student? ☐ Yes ☐ No

ABOUT THE CLAIM

This Claim is Due To: (Complete question 1. and either 2A. or 2B.)

1. Is this condition related to employment?

☐ Yes

☐ No

2A. AN ACCIDENT

Nature of injury?.....

.....

How did it happen?.....

.....

Where?.....When?..../..../....

When was a Physician consulted?..../..../....

2B. AN ILLNESS

Nature of illness?.....

.....

When did symptoms begin?...../...../.....

Name of Physician.....

Address.....

ABOUT OTHER INSURANCE

Is the Patient Covered by One or More of the Following?

Any other group insurance? ☐ Yes ☐ No Any Group prepayment plan? ☐ Yes ☐ No

Any federal, state or other government plan, or union welfare plan? ☐ Yes ☐ No

Any medical plan sponsored by a school or college? ☐ Yes ☐ No

Any auto insurance if an injury? ☐ Yes ☐ No

If "YES" to any of the above, Name and Address of Other Insurance Company

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Name of Insured

Policy Number or Certificate Number

Name and Address of Employer, Group or School Providing the Plan.

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ASSIGNMENT OF BENEFITS

I hereby direct that all hospital, surgical or medical benefits due me be paid directly to:

(Name and address of provider)

Signature of covered person.....

Please reimburse me for benefits due and I understand I am financially responsible for any expenses due the provider of service.

Signature of covered person.....

CERTIFICATION & AUTHORIZATION (to be signed by the patient (or parent if patient is a minor) and the certificate holder)

I hereby certify that the above answers and statements herein and attached are to the best of my belief accurate. I hereby authorize any hospital, physician or other insurance company to furnish Group Insurance Service Center, Inc. or its representative or permit said company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records or other company records. A photocopy of this authorization shall be considered as valid as the original.

Date:

X_____ Patient Signature

X_____ Certificate Holder Signature

PHYSICIAN OR SUPPLIER INFORMATION

Date of illness (first symptom) or injury (accident) or pregnancy (LMP)	Date first consulted you for this condition	Has patient ever had same or similar symptoms? ☐ Yes ☐ No
Name of referring physician		For services related to hospitalization, give hospitalization dates Admitted. . . . . .Discharged. . . . .
Name and address of facility where services rendered *(if other than office)*		Was laboratory work performed outside your office? ☐ Yes ☐ No Charges:

Diagnosis or nature of illness or injury.

1.
2.
3.
4.

Date of Service	Place of Service	Fully describe procedures, medical services or supplies furnished for each date given Procedure Code CPT	*(Explain unusual services or circumstances)*	Diagnosis Code ICD-9	Charges	

Signature or physician or supplier	Accept assignment (government claims only) ☐ Yes ☐ No	Total Charge	Amount Paid	Balance Due
Signed Date	Your Social Security Number or Employers I.D. Number	Physician's or Supplier's name, address, zip code & Tel. No.		
Your patient's account no.		S.S. No. or Employers I.D. No. must be furnished under authority of law		

*** Place of service codes**

1-(H)	Inpatient Hospital	4-(H)	Patient's Home	7-(NH)	Nursing Home	0-(OL)	Other Locations
2-(OH)	Outpatient Hospital	5-	Day Care Facility (PSY)	8-(SNF)	Skilled Nursing Facility	A-(IL)	Independent Laboratory
3-(O)	Doctor's Office	6-	Night Care Facility (PSY)	9-	Ambulance	B-	Other Medical/Surgical Facility