FOR GROUP BENEFIT USE ONLY:

Effective Date of Insurance For
Employee ____________ Date of Termination ____________
Dependent ____________ Initials ____________

MEDICAL / VISION CLAIM FORM

Section A — To be Completed by Employee or Surviving Spouse

Employee's Name (Please Print Full Name)	Emp. Date of Birth	Employee's Identification Number	Employer Name

Home Address	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated ☐ Domestic Partner	First Name of Spouse	Is your Spouse Employed?
No. Street	Name and Address of company where spouse is employed		
City State Zip	Spouse's Date of Birth	Spouse's Identification Number	

Has your employment terminated? ☐ Yes ☐ No Are you currently on a leave of absence? ☐ Yes ☐ No If yes, date ________

Is patient also covered for benefits by any

a. Other Group Health insurance of any kind including Blue Cross and Blue Shield? ☐ Yes ☐ No
b. Group prepayment arrangement, including HMO, providing for medical care and treatment? ☐ Yes ☐ No
c. Coverage of medical care expenses provided by a school, or by Medicare / Medicaid or other federal, state, provincial or government agency? ☐ Yes ☐ No
d. No fault automobile insurance as a result of injuries sustained in an automobile accident? ☐ Yes ☐ No

If any of the above are answered "Yes" please indicate under "Remarks" the other insurance company's name and policy number, the employee's or dependent's ID or S.S., number and the name and address of the school, employer, union or government agency.

Was illness or injury due, in any way:

a. To the patient's occupation ☐ Yes ☐ No
b. To an automobile accident ☐ Yes ☐ No
c. Any other type of accident ☐ Yes ☐ No

If any of the above are answered "Yes" give details under "Remarks". If an accident was involved, include date of accident and extent of injuries. For automobile accident, include state in which it occurred.

At the time charges were incurred:
Was your spouse employed? ☐ Yes ☐ No
If a claim is for a child was the child employed? ☐ Yes ☐ No

If the answer to either is "Yes", please show in "Remarks" the names of the persons employed, and the name and address of their respective employers.

Is the patient eligible for Medicare? ☐ Yes ☐ No If yes, effective dates: Part A ________ Part B ________ Part D (RX) ________

Remarks:

Describe Condition(s) Being Treated:

Dependent Information/Complete Section only if Patient is a Dependent

Name of dependent	Date of birth Month	Day	Year	Relationship ☐ Spouse ☐ Child ☐ Other ________ *(relationship)*	Marital status if other than spouse: ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Domestic Partner

If a claim is for dependent child 19 or older, is child enrolled as a full-time student? ☐ Yes ☐ No | Name of school | Sex: ☐ Male ☐ Female

If dependent (other than spouse) is age 19 or over: (a) is that individual wholly dependent upon you for support or maintenance? ☐ Yes ☐ No
(b) is that individual disabled? ☐ Yes ☐ No

Nature of Illness	Number of Bills attached	Covers period From	To	Total charges

AUTHORIZATION OF PAYMENT TO: ☐ EMPLOYEE ☐ PROVIDER

IMPORTANT: THE FOLLOWING AUTHORIZATION MUST ALSO BE COMPLETED

To all physicians, hospitals, medical service providers, druggists, employers and any other agencies or organizations (including other insurance companies, Blue Cross-Blue Shield and prepaid health plans).

For purposes of evaluating a claim, you are authorized to permit Group Benefit Services, Inc. and its authorized representatives to view or obtain a copy of all existing records (including those of psychiatric, drug or alcohol treatment) pertaining to the examination, medical and dental treatment, history, prescriptions, employment and insurance coverage)

I hereby certify that the above statements and attachments are correct and represent actual services, dates and fees charged to me or my eligible dependents.

Employee signature Date

HOW TO FILE YOUR CLAIM

ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE SUBJECT TO CRIMINAL PENALTIES.

1. COMPLETE SECTION A. ANSWER ALL QUESTIONS. BE SURE TO INCLUDE YOUR IDENTIFICATION NUMBER.
2. HAVE YOUR DOCTOR COMPLETE SECTION B AND RETURN IT TO YOU FOR SUBMISSION TO YOUR CLAIM OFFICE, OR ATTACH AN ITEMIZED BILL.
3. ADDITIONAL MEDICAL BILLS: ATTACH THESE TO COMPLETED SUPPLEMENTAL MEDICAL CLAIM FORM AFTER INITIAL CLAIM SUBMISSION. A NEW DOCTOR'S STATEMENT IS NOT NECESSARY IF THE DIAGNOSIS OF THE CONDITION BEING TREATED IS ON THE BILL. A DETAILED BILL MAY BE INCLUDED IF YOU DO NOT FOLLOW "4" BELOW. SUBMIT ITEMIZED BILLS. DO NO SEND CANCELLED CHECKS, CASH REGISTER RECEIPTS, OR LISTS PREPARED BY YOU. THE ACTUAL BILLS ARE NEEDED. PRESCRIPTION BILLS MUST SHOW THE PHARMACY, PRESCRIPTION NUMBER, DATE OF PURCHASE AND THE NAME OF THE PERSON FOR WHOM DRUGS ARE PURCHASED. CHARGES SUBJECT TO A POLICY DEDUCTIBLE MAY BE ACCUMULATED, AND SUBMITTED WHEN THEIR TOTAL SATISFIES THE DEDUCTIBLE AMOUNT. YOU DO NOT HAVE TO SUBMIT EACH BILL AS IT IS INCURRED.
4. HOSPITAL ADMISSION: (OPTIONAL - SEE ABOVE) — COMPLETE SECTION A. PRESENT YOUR IDENTIFICATION CARD WITH YOUR FORM AND CLAIM OFFICE ENVELOPE TO THE HOSPITAL ADMISSIONS CLERK. ASK THE HOSPITAL TO RETURN THE FORM WITH A DETAILED HOSPITAL BILL TO YOUR CLAIM OFFICE. THE HOSPITAL MAY WISH TO CONTACT THE CLAIM OFFICE TO VERIFY YOUR COVERAGE. NOTE — IN CASE OF HOSPITAL CONFINEMENT, 2 FORMS MAY BE NEEDED, ONE EACH FOR THE HOSPITAL AND DOCTOR.
5. WHERE TO SEND YOUR CLAIM: SEND YOUR CLAIM TO THE CLAIM ADDRESS SHOWN ON THE BACK SIDE OF THIS FORM.

Section B — Attending Physician's Statement

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. Patient's Name *(First name, middle initial, last name)*	2. Patient's Date of Birth Mo. / Day / Yr.	3. Insured's Name *(First name, middle initial, last name)*

12. Patient's or Authorized Person's Signature I Authorize the Release of any Medical Information necessary to process this Claim Signed Date	13. I authorize payment of medical benefits to undersigned physician or supplier for service described below Signed

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of:	Illness (First Symptom) or Injury (accident) or Pregnancy (LMP)	15. Date first consulted you for this condition	16. Has patient ever had same or similar symptoms? ☐ Yes ☐ No

17. Date patient able to return to work	18. Dates of total disability From / Through	Dates of partial disability From / Through

19. Name of referring physician	20. For services related to hospitalization give hospitalization dates Admitted / Discharged
21. Name & address of facility where services rendered (if other than home or office)	22. Was laboratory work performed outside your office?

23. Diagnosis or nature of illness or injury, relate diagnosis to procedure in Column D by reference to numbers 1, 2, 3, etc. or DX code

1.
2.
3.
4.

24. A Date of Service	B. Place of Service	C Procedure Code (Identify:)	Fully describe procedures, medical services or supplies furnished for each date given *(Explain unusual services or circumstances)*	D Diagnosis Code	E Charges	F

25. Signature of physician or supplier Signed Date	26. Accept assignment (Government Claims only) (See Back) ☐ Yes ☐ No	27. Total charge	28. Amount paid	29. Balance due
	30. Your Social Security No.	31. Physician's or supplier's Name, address, zip code & Telephone No		
32. Your Patient's Account No.	33. Your Tax Identification No.	I.D. No.		

*Place of Service Codes

1 — (IH) — Inpatient Hospital	4 — (H) — Patient's Home	7 — (NH) — Nursing Home	0 — (OL) — Other Location
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

Send the completed Health Claim Form and itemized bills to:

Group Benefit Services, Inc.
Attention: Claims Department
P.O. Box 4368
Lutherville, MD 21094-9998
Baltimore (410) 832-1333
Wats 1 - (800) 337-4973