

STATEMENT OF CLAIM FORM AND ACCIDENT FORM

INSTRUCTIONS FOR FILING CLAIM

WHEN YOU HAVE INCURRED MEDICAL EXPENSES COVERED BY YOUR GROUP PLAN:

1. Complete the Employee's Statement
2. Attach the bills for the medical expense benefits you are claiming.

The bills must show the:

- Patient's name
- Condition being treated (Diagnosis)
- Type of treatment given
- Date the expense was incurred
- Charges made

A Physician's Statement is provided on the other side of this form (Physician or Supplier Information Section) if the provider prefers to use it instead of a separate itemized billing (such as on a HCFA 1500 form).

3. If you are filing your first claim for services rendered in the pre-existing conditions exclusionary period, please attach a list of the **NAMES AND COMPLETE MAILING ADDRESSES** of all doctors and pharmacies who have provided treatment or prescriptions in the previous two years. The pre-existing conditions exclusionary period may be reduced with creditable coverage from prior health plans. If you have not submitted a copy of the creditable coverage certificate, please send it with your doctor/pharmacy list. You may request a copy of this certificate from your prior health plan's customer service department.
4. Mail claim directly to Claim Supervisor (Med-Pay, Inc.) at the address on your ID card unless the ID card states otherwise.

Med-Pay, Inc.

P.O. Box 10909
Springfield, MO 65808
(417) 886-6886
1-800-777-9087

GROUP NAME: _____
GROUP NUMBER: _____

EMPLOYEE'S STATEMENT

PART 1

Fully Complete For All Claims	Employee's Name (Please Print) _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	Plan No. _____	Your Date of Birth _____	Social Security Number _____	
	Address: Street and No. _____			City _____	State _____	Zip Code _____	
	<input type="checkbox"/> Active	<input type="checkbox"/> Retired	This claim is on:		<input type="checkbox"/> Myself	<input type="checkbox"/> My Spouse	<input type="checkbox"/> Dependent Child
	Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, give spouse's information below:				
Complete For All Claims	Name of Spouse _____			Spouse's Date of Birth _____			
	Name of Spouse's Employer _____			Address _____			
	Nature of sickness or injury for which claim is made _____			Date last worked _____	Date sickness began _____	Date of first expense for this condition _____	
	Are any of the expenses for which this claim is being made covered by any other group insurance, group Blue Cross/Blue Shield, Medicare, Medicaid, Veterans or union welfare plan? (Including any insurance or coverage carried by a dependent.) <input type="checkbox"/> Yes <input type="checkbox"/> No						
Complete For All Injuries Employee or Dependent	If yes, give the name and address of the insurance company and/or organization providing such benefits. Name _____ Address _____						
	Policy Number or Contract Number _____						
	Date of the injury _____		Where did the injury occur? _____		How did the injury occur? _____		
	Is injury due to automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Complete Only For Dependent Claims	Is this a work related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Has or will claim be filed under any Workmen's Compensation Act or similar law? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Name of Dependent _____		Sex _____	Date of Birth _____	Relationship of Dependent _____		<input type="checkbox"/> Married <input type="checkbox"/> Single
	Date this dependent became covered _____	If employed or attending school give the name of employer or school and dependent's Social Security Number _____					
Sign Here	I HEREBY AGREE TO REIMBURSE MY EMPLOYER TO THE EXTENT OF ANY OVERPAYMENT WHICH IS IN EXCESS OF THE AMOUNT PAYABLE UNDER THE PLAN. THE STATEMENTS ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY BELIEF. I AUTHORIZE ANY HOSPITAL OR PHYSICIAN TO FURNISH ANY INFORMATION REQUESTED. ALSO, I HEREBY AUTHORIZE MY EMPLOYER OR MED-PAY, INC. TO RELEASE OR OBTAIN FROM ANY ORGANIZATION OR PERSON ANY INFORMATION WHICH MAY BE NECESSARY TO DETERMINE BENEFITS PAYABLE UNDER THE PLAN WITH MY EMPLOYER. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.						
	X _____		DATE _____		PATIENT'S SIGNATURE _____		
	EMPLOYEE'S SIGNATURE		DATE		PATIENT'S SIGNATURE		

HEALTH BENEFIT CLAIM FORM

TYPE OR PRINT

PART 2

PATIENT & PLAN MEMBER INFORMATION (COMPLETE PART 2 FOR ASSIGNMENT OF BENEFITS)		
1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. PLAN MEMBER'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, zip code)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. INSURED'S I.D. No. or MEDICARE NO. (Include any letters)
	7. PATIENT'S RELATIONSHIP TO PLAN MEMBER SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. PLAN NUMBER (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE (Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number)	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	11. PLAN MEMBER'S ADDRESS (Street, city, state, zip code)
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 PHYSICIAN OR SUPPLIER FOR SERVICES. SIGNED (Plan Member or Authorized Person) _____

PART 3

PHYSICIAN OR SUPPLIER INFORMATION (PART 3 NECESSARY ONLY IN THE ABSENCE OF ITEMIZED STATEMENT FROM PHYSICIAN OR SUPPLIER)								
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 <input type="checkbox"/> NO <input type="checkbox"/>					
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? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES: _____					
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. DATE SERVICE	A.	B.* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY:) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES			
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; height: 100px;"> </td> <td style="width:33%;"> </td> <td style="width:33%;"> </td> </tr> </table>								
25. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____			26. ACCEPT ASSIGNMENT YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE			
30. YOUR SOCIAL SECURITY NO.			28. AMOUNT PAID					
32. YOUR PATIENT'S ACCOUNT NO.			29. BALANCE DUE					
33. YOUR EMPLOYER I.D. NO.			31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.					
I.D. NO.								

*PLACE OF SERVICE CODES
 1 - (IH) - 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

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74