MEDICAL CLAIM FORM

EMPLOYER ______________________ **Group Number:** ______________________

EMPLOYEE

Employee's Name (Please Print Full Name) Last First Middle Initial	Employee's Social Security Number
Address	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
City State Zip	
Employee's Date of Birth / / Month Day Year	Name of Spouse
Does Spouse's Employer provide a group Health Insurance Plan? ☐ Yes ☐ No	If YES, Is the patient for this claim covered by that plan? ☐ Yes ☐ No

PATIENT

Patient's Name (if other than employee) Last First Middle Initial	Patient's Social Security Number
Patient's Date of Birth / / Month Day Year	Relationship to Employee
Is above named Patient covered under any other insurance which provides benefits for Hospital, Surgical, or Medical Treatment? ☐ Yes ☐ No If YES, Pleas provide Name, Address, & Policy # of other insurance company:	
If Patient is Adult child are they a Full Time Student? ☐ Yes ☐ No If yes, complete shaded questions.	Is Adult Child Employed full time? If YES, complete below. ☐ Yes ☐ No
Name of School or Employer	School or Employer Address
Tuition paid through	Number of Credit Hours

INJURY

If Injury Occurred, complete below. Where did injury occur?	How did it happen?
Was the accident connected with the Patient's employment? ☐ Yes ☐ No	Auto Accident? ☐ Yes ☐ No
Date of Accident / / Month Day Year	Any other Insurance Involved? ☐ Yes ☐ No If So, Name, Address, Policy #, of other Company

AUTHORIZTION TO OBTAIN INFORMATION

I AUTHORIZE the disclosure of relevant information about me for the purpose of evaluation and administrating my claim. I AUTHORIZE the following to disclose such information: Any Physician, Medical Professional, Hospital, Clinic, Other Medical or Mentally Related Facility, Insurance or Reinsurance company, Consumer reporting agency, Medical or Hospital service, Prepaid health plan, Employer, Group Policy Holder or Benefits Plan Administrator. They may disclose such information to Benicomp, Inc., Insurers and/or Reinsures and any benefits plan administrator, consumer reporting agency, Agent or independent claim administrator acting on its behalf. I UNDERSTAND that relevant information for claims purposes includes employment related information and information about medical care, advice, diagnosis, treatment, supplies provided mental illness, and drug or alcohol abuse. I UNDERSTAND that Benicomp, Inc. will not release the information EXCEPT to insurance companies and/or reinsurance companies, to other persons or organizations performing business or legal services in connection with my claim, or as the law otherwise requires or permits. I KNOW that I may receive a copy of this Authorization upon request. I AGREE that a photographic copy of this Authorization shall be valid as the original. I AGREE that this Authorization shall be valid for: 1. Claims of Health Insurance Benefits, for one year from the date shown below or for the term of coverage and the policy, whichever is shorter, or 2. All claims, for one year from the date shown below or for the duration of the claim, whichever is shorter.

Dated at ____________________, this __________ Day of ________________________, 20____

Name of Claimant: __________________________________ Relationship of Authorized Person to Claimant________________

Signature of Claimant or Authorized Person: ____

Submit completed form to:

BeniComp Inc.

8310 Clinton Park Drive · Fort Wayne, Indiana 46825

(260) 482-7400 ▪ 1-800-837-7400

I Authorize Payment Of Medical Benefits To Physicians Or Supplier Of Service

Employee Signature

PHYSICIAN ■ SUPPLIER INFORMATION

Patient Name	Date of Service / / Month Day Year
Check One: ☐ Illness (first symptom) ☐ Injury (Accident) ☐ Pregnancy (LMP)	Date First Consulted You For This Condition: / / Month Day Year
Has Patient Ever Had Some Or Similar Symptoms? ☐ Yes ☐ No	Date Patient Able To Return To Work: / / Month Day Year
Dates Of Total Disability: From: Through:	Dates Of Partial Disability: From: Through:
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 Home Or Offices)	Was Laboratory Work Preformed Outside Your Office? ☐ Yes ☐ No

Diagnosis Or Nature Of Illness Or Injury. (Related Diagnosis To Procedure In Column By Reference To Numbers 1,2,3 etc. Or DX Code)
1.
2.
3.

Date of Service	Place of Service	Fully Describe Procedure, Medical Services, or Supplies Furnished For Each Date Given.		Diagnosis Code	Charges	
		Procedure Code	Explain Unusual Services or Circumstances			

Signature of Physician or Supplier Signature Date	Total Charge	Amount Due	Balance Due

Physician's or Supplier's Name, Address, Zip Code & Telephone Number: I.D. No.	Accept Assignment? (Government Claims Only) ☐ Yes ☐ No Your Social Security Number:
Your patient's Account Number:	Your Employer I.D. Number:

Place of Service Codes

1-(IH)-Inpatient Hospital	4-(H)-Patient's Home	7-(NH)- Nursing Home	O-(OL)- Other Location
2-(OH)-Outpatient Hospital	5-Day Care	8-(SF)- Skilled Nursing Facility	A- (IL) – Independent Laboratory
3-(IO)- Doctors Office	6-Night Care Facility	9-Ambulance	B- Other Medical/ Surgical Facility