Group Medical Claim Form

Submit Claims to: P.O. Box 5490 • Salem, OR 97304 • 800.893.9230

1. Your Policy and/or Group number(s)

2. Name and address of employer

EMPLOYEE INFORMATION

3. Name of employee *(insured)*	☐ Male ☐ Female	Date of Birth	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

4. Address of employee Street	City	State	Zip Code	5. Employee's SS number

6. Name of Spouse	Spouse's Date of Birth	Spouse's SS number

7. (a) Are you or any member of your family covered under Medicare? ☐ Yes ☐ No
(b) Are you or any member of your family covered under another Group Plan providing medical benefits? ☐ Yes ☐ No

REMARKS: If you have checked yes to any of the above, please provide policy number:
Effective Date:
Name of insured:
Name and address of Insurance Company:
Name and address of the employer, (school, union) or organization which sponsors the coverage:

If you are covered by Medicare, or any other basic hospitalization or surgical plan such as Blue Cross-Blue Shield, please submit there carrier's payment statements of declination along with itemized bills.

COMPLETE FOR INJURY OR ILLNESS

8. This claims is for ☐ Employees ☐ Spouse ☐ Child

9. This claim is for ☐ ILLNESS
Give time and date, briefly describe how injury occurred.
☐ ACCIDENT ON
Does this claim involve a work-related illness or injury? ☐ Yes ☐ No

IF CLAIM FOR DEPENDENT, COMPLETE THIS SECTION ALSO

10. Name of your dependent	☐ Male ☐ Female	Date of Birth	SS number if dependent child 18 or over

11. Is dependent employed? ☐ Yes ☐ No Name and phone number if dependent child 18 or over
Is dependent a full-time student? ☐ Yes ☐ No

12. Address of employer or school Street City State Zip Code

IMPORTANT – PLEASE COMPLETE AUTHORIZATION SECTION

13. AUTHORIZATION TO RELEASE INFORMATION:
The above answers are true and correct to the best of my knowledge. I hereby authorized any physician, surgeon, practitioner or other person, any hospital, including veterans administration or government hospital, any medical service organization, and insurance company, or any other information acquired, including benefits paid or payable, concerning this or other disabilities. A Photostat of this authorization shall be as valid as the original.

_____
Signed (Patient or Parent if Minor) Date

14. AUTHORIZATION TO PAY INSURANCE BENEFITS:
I hereby authorize payment directly to the Physician named above those benefits otherwise payable to me but not to exceed the Physician's regular charges. I understand I am financially responsible to the Physician for charges not covered by this authorization.

_____
Signed (Patient or Parent if Minor Date

Please attach itemized bills to this form and mail to: PH Tech