MEDICAL CLAIM FORM

BAS **Benefit Administrative Systems, LLC**

17475 Jovanna Dr., 1B, Homewood, IL 60430 708-799-7400 Fax: 708-799-7533

Six Executive Dr., Suite 1, Fairview Heights, IL 62208 618-632-8539 Fax: 618-628-0289

PART 1 EMPLOYEE AND EMPLOYER INFORMATION

EMPLOYEE'S NAME (LAST) (FIRST) (MIDDLE)	EMPLOYEE'S DATE OF BIRTH / /	EMPLOYER'S NAME
EMPLOYEE ADDRESS (STREET) IS THIS A NEW ADDRESS? ☐ YES ☐ NO	EMPLOYEE STATUS ☐ ACTIVE ☐ LEAVE OF ABSENCE ☐ RETIRED ☐ COBRA	EMPLOYER'S ADDRESS (STREET)
(CITY) (STATE) (ZIP) (PHONE)	EMPLOYEES SOCIAL SECURITY NUMBER – –	(CITY) (STATE) (ZIP) (PHONE)

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DO YOU HAVE MORE THAN ONE EMPLOYER? ☐ YES ☐ NO

If yes, name and address of employer NAME ______ (STREET) ______

CITY ______ STATE ______ ZIP ______ PHONE ______

PART 2 PATIENT AND CLAIM INFORMATION

PATIENT'S NAME (LAST) (FIRST) (MIDDLE)	PATIENT'S DATE OF BIRTH / /	IF DEPENDENT CHILD IS OVER AGE 19, INDICATE ☐ HANDICAPPED ☐ FULL-TIME STUDENT
PATIENT'S ADDRESS (If different than employee)	PATIENT'S SEX ☐ MALE ☐ FEMALE	GIVE NAME OF SCHOOL ______ (A letter from the registrar's office confirming full time student status must be submitted each semester.)
(CITY) (STATE) (ZIP) (PHONE)	PATIENT'S RELATIONSHIP TO THE INSURED ☐ SELF ☐ CHILD ☐ SPOUSE ☐ STEPCHILD ☐ OTHER ______	IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS? ☐ YES ☐ NO

WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT? ☐ YES ☐ NO B. AN ACCIDENT? ☐ YES ☐ NO	**IF AN ACCIDENT** date ______ 19 ______ and time ______ ☐ AM ☐ PM IS A THIRD PARTY LIABLE FOR ACCIDENT? ☐ YES ☐ NO description (how & where) ______

PART 3 SPOUSE AND OTHER COVERAGE INFORMATION

SPOUSE'S NAME (LAST) (FIRST) (MIDDLE)	IS YOUR SPOUSE EMPLOYED ☐ YES ☐ NO IF YES, EMPLOYERS NAME
ADDRESS If different than the Employee (STREET)	ADDRESS (STREET)
(CITY) (STATE) (ZIP) (PHONE)	(CITY) (STATE) (ZIP) (PHONE)

DOES EMPLOYEE OR ANY FAMILY MEMBER HAVE OTHER HEALTH INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

TYPE OF COVERAGE: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUG

TYPE OF INSURANCE: ☐ OTHER EMPLOYER SPONSORED PLAN ☐ MEDICARE ☐ NO-FAULT ☐ CHAMPUS ☐ STUDENT INSURANCE

NAME OF COVERED PERSON	NAME AND ADDRESS OF OTHER INSURANCE CARRIER/ADMINISTRATOR	PHONE #	COVERAGE SINGLE	COVERAGE FAMILY
			☐	☐
			☐	☐

PART 4 ASSIGNMENT OF BENEFITS

AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I hereby authorize payment of medical benefits to the provider of services as indicated on the submitted claims, if not otherwise payable to me.

EMPLOYEE'S SIGNATURE DATE

PART 5 AUTHORIZATION FOR RELEASE OF RECORDS (COMPLETE FOR ALL CLAIMS)

I hereby authorize any insurance company, prepayment organization, employer hospital, physician, pharmacy, clinic or any other organization to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information in support of this claim is true and correct. A photostat of this authorization shall be as valid as the original.

DATE ______ SIGNATURE OF EMPLOYEE ______

DATE ______ If claim is on spouse, SPOUSE'S SIGNATURE ______