

MEDICAL CLAIM FORM
Complete this form & attach all bills

MAIL TO 



**Medical Claims Dept.
PO Box 46686
Cincinnati, OH 45246**

PART 1 MUST BE COMPLETED BY EMPLOYEE, PLEASE REFER TO INSTRUCTIONS ON REVERSE SIDE

EMPLOYEE NAME		MEMBER NUMBER		NAME OF EMPLOYER	
HOME ADDRESS		EMPLOYEE DATE OF BIRTH		GROUP NUMBER	
CITY, STATE, & ZIP		HOME PHONE NUMBER		WORK PHONE NUMBER <i>(OPTIONAL)</i>	
PATIENT NAME (<input type="checkbox"/> Female <input type="checkbox"/> Male) (IF OTHER THAN EMPLOYEE)	IF OVER AGE 19, IS PATIENT FULL TIME STUDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	RELATIONSHIP TO EMPLOYEE	PATIENT DATE OF BIRTH	IS PATIENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF FULL TIME STUDENT, NAME OF SCHOOL: _____ # OF HOURS ENROLLED? _____					
DATE ACCIDENT OR ILLNESS BEGAN	IF INJURED, HOW & WHERE DID ACCIDENT HAPPEN?		DID ACCIDENT OCCUR AT WORK?		
NATURE OF ILLNESS, INJURY, DIAGNOSIS OR MEDICAL CAUSE?			PHYSICIAN'S NAME		
			PHYSICIAN'S PHONE NUMBER		
NAME OF SPOUSE		SPOUSE DATE OF BIRTH	IS SPOUSE EMPLOYED? IF YES, NAME & ADDRESS OF EMPLOYER.		
ARE YOU, THE PATIENT OR SPOUSE COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE NAME, ADDRESS, AND POLICY NUMBER OF PLAN PROVIDING BENEFITS.					
NAME & ADDRESS, INCLUDING CITY, STATE, & ZIP: _____					
SOCIAL SECURITY NUMBER: _____ POLICY NUMBER: _____					

ASSIGNMENTS OF BENEFITS

A SIGNATURE IS REQUIRED AS AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER(S)

I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

Signature of Covered Person

Date

AUTHORIZATION TO RELEASE INFORMATION (A patient or parent must sign below)

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician 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 hereby certify the information provided is correct and true to the best of my knowledge.

Signature of Patient or Parent (if minor)

Date



PROCEDURES FOR FILING A CLAIM

1. Complete the "Employee, Part 1" section of the form. Make sure you include your SSN and your employer or group name. If the patient is your dependent be sure to complete all questions, including, if married and if a full time student. It is important to know when, how and where your accident, illness or disability began, especially if it is job related. Questions regarding other coverage you or your dependent are eligible for must be answered.
2. If you have other coverage, including Medicare or CHAMPUS, make sure you attach all payment statements or declination letters, this will speed up the payment process.
3. Have your physician complete "Part2". Attach all medical bills relating to claim, make sure all bills identify patient, and all bills should show date of treatment, type of service, and amount of charges. Make a final check to see that all parts of the claim form are complete.
4. Mail all claims to S&S Healthcare Strategies, LTD, PO Box 46511, Cincinnati, OH 45246-0511.

PART 2 TO BE COMPLETED BY THE PHYSICIAN

PATIENT'S NAME	PATIENT'S DATE OF BIRTH	DOES PATIENT HAVE OTHER COVERAGE? (If yes, please identify)
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IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES _____ NO _____
GIVE DETAILS

PREGNANCY? YES _____ NO _____	APPROXIMATE DATE PREGNANCY COMMENCED
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DIAGNOSIS AND CONCURRENT CONDITION:

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES _____ NO _____
IF YES, WHEN AND DESCRIBE

REPORT OF SERVICES OR ATTACH ITEMIZED BILL				
DATE OF SERVICE	PLACE OF SERVICE	BRIEF DESCRIPTION OF SERVICE RENDERED	PROCEDURE CODE	FEE CHARGED
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE FIRST CONSULTED FOR CONDITION	TOTAL CHARGES	\$
		AMOUNT PAID	\$
IS PATIENT STILL UNDER YOUR CARE FOR CONDITION? YES _____ NO _____		BALANCE DUE	\$

PHYSICIAN'S NAME _____ GROUP PRACTICE NAME _____

CITY, STATE, ZIP CODE _____ PHONE (____) _____ FAX _____

Direct Payment Cannot Be Made If Not Provided

TAX ID#: _____

PHYSICIAN'S SIGNATURE

DATE

SSN#: _____