Group Medical Claim Form

MAIL COMPLETED CLAIM FORMS TO:
Advantek Benefit Administrators
P.O. Box 45007
Fresno, CA 93718

(866) 556-7655 – Business
(559) 228-5460 – Fax

Provider Section and Instructions on Reverse Side

EMPLOYEE INFORMATION: Employee Complete This Section

A. EMPLOYEE'S NAME (*First, M.I., Last*)	OCCUPATION	B. DATE OF BIRTH	C. SEX θ M θ F
D. EMPLOYEE'S MAILING ADDRESS (*Street, City, State, Zip) and DAYTIME PHONE #*	IS THIS A CHANGE OF ADDRESS? θ Y θ N	E. EMPLOYEE'S SOC. SEC. /ID NO.	
F. MARITAL STATUS	G. EMPLOYER	H. EMPLOYEE STATUS DATE θ ACTIVE θ HOURLY θ RETIRED θ COBRA θ SALARIED θ DISABLED	

PATIENT INFORMATION: Complete Only if Patient is Other Than Employee

A. PATIENT'S NAME (*First, M.I., Last*)	B. RELATIONSHIP TO EMPLOYEE	C. DATE OF BIRTH	D. SEX θ M θ F
E. COMPLETE THIS INFORMATION IF A PATIENT IS AN UNMARRIED DEPENDENT CHILD	DEPENDENT CHILD IS: θ EMPLOYED FULL-TIME θ STUDENT FULL-TIME	NAME, ADDRESS AND PHONE # OF CHILD'S SCHOOL/EMPLOYER	

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION:
Complete Only if a Claim is a Result of an Accident or Occupational Illness/Injury

A. DESCRIPTION OF θ ACCIDENT OR θ ILLNESS (How, When, Where)		B. ACCIDENT OR ILLNESS DUE TO EMPLOYEMENT? θ Y θ N
C. DATE OF ACCIDENT OR BEGINNING OF ILLNESS	**D. INJURY DUE TO AUTO ACCIDENT** θ Y θ N	E. HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE A CLAIM FORM FOR WORKERS' COMPENSATION BENEFITS? θ Y θ N
F. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS? θ Y θ N		

FAMILY OTHER COVERAGE INFORMATION:
Complete Only if Claim is for a Dependent and/or Other Coverage is in Effect

A. SPOUSE EMPLOYED θ Y θ N	IF NO, HAS SPOUSE BEEN EMPLOYED DURING THE LAST 12 MONTHS? θ Y θ N	B. NAME OF SPOUSE	SPOUSE'S DATE OF BIRTH
C. SPOUSE'S SOC.SEC./ID.NO	D. NAME, ADDRESS AND PHONE # OF SPOUSE'S EMPLOYER		
E. IS THE PATIENT COVERED UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OR DISABILITY LOSSES OF THIS CLAIM? θ Y θ N IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY, ORGANIZATION, OR HMO PROVIDING BENEFITS.			
NAME & ADDRESS			POLICY NUMBER

EMPLOYEE'S/PATIENT'S SIGNATURE AND RELEASE: Employee Must Sign all Claims

A. AUTHORIZATION TO RELEASE INFORMATION – I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employement related information, to the Plan Administrator or their authorized agents for the purpose of validating and determing benefits payable. I will receive a copy of this authorization upon request. This authorization or a copy shall be valid for one year from the date of signature. I certify that this information is true and correct.

PATIENT'S SIGNATURE (Parent or Guardian if Claim is on a Minor)		DATE
B. PAYMENT AUTHORIZATION: - I authorize payment directly to those Health Care Providers described below and/or as indicated on the enclosed bills, of Medical Benefits otherwise payable to me, for services rendered by them.	**IF YES, EMPLOYEE'S SIGNATURE**	**DATE**

PHYSICIAN or PROVIDER: Complete This Section

Diagnosis or Nature of Illness or Injury – Relate diagnosis to procedure in column D by reference to numbers 1, 2, 3, etc. or ICD-9 Code. 1. 2. 3. 4.	DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED FOR THIS CONDITION	HOSPITAL CONFIRMATION DATES FROM TO
	DATE ABLE TO RETURN TO WORK	TOTAL DISABILITY DATES FROM TO	PARTIAL DISABILITY DATES FROM TO
	NAME AND ADDRESS OF REFERRING PHYSICIAN OR OTHER SOURCE		

A. DATE OF SERVICE	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (CPT-4)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. ICD-9 DIAGNOSIS CODES	E. CHARGES

YOUR PATIENT ACCOUNT #	**PHYSICIAN'S OR PROVIDER'S TAX IDENTIFACTION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING.** **TAX I.D. #**	PHYSICIAN OR PROVIDER'S NAME AND ADDRESS	TOTAL CHARGE AMOUNT PAID
	SOC.SEC #	PHYSICIAN'S OR PROVIDERS TELEPHONE NUMBER ( )	BALANCE DUE
I Certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.		**PHYSICIAN'S OR PROVIDERS SIGNATURE**	DATE

INSTRUCTIONS FOR FILING A CLAIM

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

YOU SHOULD SUMBIT YOUR CLAIMS MONTHLY OR WHEN YOU HAVE BILLS TOTALING MORE THAN $200.00;
YOU MUST USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY

1. **IMPORTANT**
   - A completed claim form must be included with each submission for each member of the family for each separate accident or illness.
   - Your claim cannot be processed without your Social Security Number (Employee Section, Block E)
   - You must sign and date your claim form (Employee's / Patient's Signature and Release Section)

2. **ATTENDING PHYSICIAN OR PROVIDER INFORMATION SECTION SHOULD BE COMPLETED FOR . . .**
   Surgery Doctor's Visits Mental Illness Expenses Hospital Confinement
   Be certain to include procedure code and ICD-9 Diagnosis Code (Physician or Provider Section, blocks C and D).

3. **IF ENCLOSING ITEMIZED BILLS, THEY MUST INCLUDE:**

Employee Name	Date of Service
Patient Name	Diagnosis
Type of Service	Charge for Service

   - Be certain to include Physician or Tax Identification Number.
   - Bills will not be returned to you – make copies for your records.
   - Receipts, balance due statements and cancelled checks are not acceptable.

4. **ADDITIONAL INFORMATION**
   Save your Explanation of Benefits – Duplicate vouchers are not available.
   Second Opinion Surgical Program – Call your benefits counselor for details.

5. **MAILING INSTRUCTIONS**

   Send your **completed claim** form and itemized bills to the address indicated on the front of this form.