GROUP MEDICAL CLAIM FORM

SUBMIT CLAIMS TO: P.O. BOX 45018 • FRESNO, CA 93718-5018 • (559) 499-2450

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 Social Security number

6. Name of Spouse	Spouse's Date of Birth	Spouse's Social Security 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 these carrier's payment statements or declinations along with itemized bills

COMPLETE FOR INJURY OR ILLNESS

8. This claim is for ❑ Employee ❑ Spouse ❑ Child

9. This claim is for ❑ ILLNESS

GIVE TIME AND DATE. BRIEFLY DESCRIBE HOW INJURY OCCURED.

❑ 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	Social Security number if dependent child 18 or over

11. Is dependent employed? ❑ Yes ❑ No — Name and phone number of dependent's employer or school
    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 authorize any physician, surgeon, practitioner or other person, any hospital, including veterans administration or government hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or 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 Physicians for charges not covered by this authorization

Signed (Patient or Parent if Minor) ____________ Date ____________

Please attach itemized bills to this form and mail to : HEALTH COMP, INC.

The form on the reverse side is designed to simplify filing a Major Medical Claim. When you have medical bills to submit, please note the following:

INSTRUCTIONS FOR COMPLETION OF YOUR MAJOR MEDICAL CLAIM STATEMENT

ALL CLAIMS

- Please submit **ITEMIZED BILLS**-Bills showing only **balance due**, cash register receipts, and copies of cancelled checks can not be processed. Be sure the bills show full name of patient, diagnosis, date of service, type of service (e.g., x-ray), and the charge for each service. Bills showing no diagnosis will be treated as routine care. Note: only one claim form is needed per **CLAIMANT** per submission.

- **IMPORTANT NOTE ON COMPLETING YOUR CLAIM FORM: Please refer to your ID card when completing the first box.**

Submit Claims to:

Health Comp, Inc.
P.O. Box 45018
Fresno, CA 93718-5018