



MEDICAL CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION


1. MEMBER ID:		Please refer to your medical ID card:											
		<table border="1" style="border-collapse: collapse; width: 100%; height: 20px;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">D</td> </tr> </table>											D
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2. Patient's Name	3. Patient's Date of Birth	4. Employee's Name											
5. Patient Address (Street, City, State, Zip Code)	6. Patients Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Employee's Address (Street, City, State, Zip Code)											
8. Patients Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		<input type="checkbox"/> CHECK HERE IF NEW ADDRESS											
9. OTHER HEALTH INSURANCE COVERAGE: Is patient covered by any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No													
If yes, provide name and address of carrier: _____													
Identification Number _____ Name of Employer _____													
Types of Coverage by Carrier: <input type="checkbox"/> Medical <input type="checkbox"/> Drug <input type="checkbox"/> Vision <input type="checkbox"/> Dental													
Effective Date of Coverage _____ Termination Date of Coverage _____													
10. Was condition related to accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give details:													
When did the accident occur? (MM/DD/YY) _____													
11. Was condition related to Patient's Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No When did the injury occur? (MM/DD/YY) _____													
12. If services are for Massage Therapy, check the following: <input type="checkbox"/> 97124 Massage Therapy <input type="checkbox"/> 723.9 Diagnosis													
13. I authorize the undersigned physician to release any information acquired in the course of my examination or treatment.		14. I authorize payment of medical benefits to undersigned physician or supplier for service(s) described below.											
_____	_____	_____	_____										
Signed (Employee or Patient)	Date	Signed (Employee or Patient)	Date										

REFER TO THE BACK OF YOUR I.D. CARD FOR PROPER MAILING ADDRESS



Participant Name: JOHN SAMPLE Participant ID: XEL999SMPL000D	PlanName
Group#: W0000000 Rx Bin: 000000 Rx Group: RX0000 Rx PCN: ABC Pharmacy: Pharmacy Name	<div style="border: 1px solid black; padding: 5px; background-color: #ffffcc;"> Always include trailing D and three digit alpha prefix from Member ID. </div>

(Name of Company) has hired Delta Health Systems to handle member contact for health plan administration. See back for contact information. Please verify the patient's identification.



Attach itemized bill. Each itemized bill must include:

- Name and address of provider
- Date of service
- Provider Tax ID
- Provider NPI
- Name of patient
- Amount charged for each service
- Service provided
- Diagnosis Code
- Procedure Code