# GROUP MEDICAL CLAIM FORM

HealthComp
Third Party Administrators

**SUBMIT CLAIMS TO: P.O. BOX 45018, FRESNO, CA 93718-5018 Phone: (800) 442-7247**

**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 or Domestic Partner** | **Date of Birth** | **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 or Domestic Partner ☐ Child

**9. This claim is for** ☐ ILLNESS

**GIVE TIME AND DATE. BRIEFLY DESCRIBE HOW INJURY OCCURRED.**

☐ 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
**Is dependent a full-time student?** ☐ Yes ☐ No
**Name and phone number of dependent's employer or school**

**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 authorized 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 Physician for charges not covered by this authorization.

**Signed (Patient or Parent if Minor)**
**Date**

**Please attach itemized bills to this form and mail to : HEALTHCOMP, INC.**