

Statement of Claims

Instructions for Filing Claim

When you have incurred Medical Expenses Covered by your group policy:

1. Complete the Employee's Statement below and
2. Attach the bills for the medical expense benefits you are claiming.

The bills must show the

- Patient's name
- Condition being treated (Diagnosis)
- Type of treatment given
- Date the expense was incurred
- Charges made

A Physician's Statement is provided on the other side of this form if you prefer to use it instead of the itemized Doctor's Bill

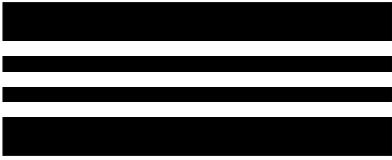
3. If patient was confined to a hospital, attach the hospital bill.
4. Mail the completed claim to:

Corporate Systems Administration, Inc.
 PO Box 4985
 Johnson City, TN 37602-4985
 Telephone: 423-282-3420

Employee's Statement

Fully	Employee's Name (please print)		Policy No.	Date of Birth	Soc. Sec. Number
	City	State	Zip	Address: Street and No.	
Complete	Active Retired		This claim is on:		Dependent Child
	Are you married Yes No		If yes, is your spouse employed?		Yes No
For	If yes, please complete the following: Spouse Name			Soc. Sec. Number	
	Name of Spouse's Employer			Address	
All	Nature of sickness or injury.		Date last worked	Date sickness began	Date of first expense for this condition
	Are any of the expenses for which this claim is being made covered by any other group insurance, group Blue Cross /Blue Shield, federal plan or union welfare plan? (Including any insurance or coverage carried by a dependent.) Yes No If yes, give the name and address of the insurance company and/or organization providing such benefits. Name _____ Address _____ _____ Policy Number/Contract Number: _____				
Complete for all injuries	Date of Injury		Where did the injury occur?	How did the injury occur?	
	Is injury due to automobile accident? Yes No Has or will claim be filed under any Workmen's Compensation Act or similar law? Yes No				
Complete only for Dependent Claims	Name of Dependent		Date of Birth	Relationship of dependent	Married Single
	Date you insured this dependent			If employed or attending school, give the name of employer/school	
Sign Here	I hereby authorize the release to and the use by Corporate Systems Administration, Inc. of any medical or other information needed in processing this claim and I further authorize payment direct to the hospital, physician and/or anesthetist of all benefits accruing to me under the terms of my certificate. Date _____ Employee sign here _____				

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM DD YY SEX M F 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other 7. INSURED'S ADDRESS (No., Street)

CITY STATE 8. PATIENT STATUS Single Married Other

ZIP CODE TELEPHONE (Include Area Code) () CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) ()

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F b. AUTO ACCIDENT? PLACE (State) YES NO

c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? YES NO c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

1. 2. 3. 4. 23. PRIOR AUTHORIZATION NUMBER

Table with 11 columns (A-K) and 6 rows. Columns include: DATE(S) OF SERVICE, Place of Service, Type of Service, PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS MODIFIER), DIAGNOSIS CODE, \$ CHARGES, DAYS OR UNITS, EPSDT Family Plan, EMG, COB, RESERVED FOR LOCAL USE.

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION