

CLAIM FORM



Construction Company, Inc.

FRINGE BENEFIT COORDINATORS

1239 NW 10TH Ave

Gainesville, FL 32601

(352) 377-1239 8:30 a.m. to 5:00 p.m. EST.

PART 1 EMPLOYEE STATEMENT

PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME		SOCIAL SECURITY #	NAME OF EMPLOYER	
EMPLOYEE ADDRESS		EMPLOYEE BIRTH DATE	OCCUPATION	GROUP NUMBER
CITY & STATE	ZIP	PHONE NO.	IS THE PATIENT A FULL TIME STUDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	NAME AND ADDRESS OF SCHOOL
DEPENDENT NAME		RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT NAME		RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DEPENDENT NAME		RELATIONSHIP	DATE OF BIRTH	IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DATE ACCIDENT OR SICKNESS BEGAN		NATURE OF SICKNESS, INJURY, DIAGNOSIS OR MEDICAL VISIT?		IS CONDITION WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?				
HAVE YOU BEEN TREATED FOR THIS ILLNESS OR INJURY IN THE LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, NAME AND ADDRESS OF ATTENDING PHYSICIAN	
NAME AND SOC. SEC. # OF SPOUSE		BIRTHDATE	IS SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME AND ADDRESS OF SPOUSE'S EMPLOYER
IS THE PATIENT COVERED UNDER ANY OTHER MEDICAL OR DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF YES, COMPLETE THE FOLLOWING:				
NAME AND RELATIONSHIP TO PATIENT:		SOCIAL SECURITY #:		EFFECTIVE DATE:
PLAN NAME AND ADDRESS:		GROUP PLAN #:		

PATIENT OR PARENT MUST SIGN AND DATE BELOW IF PAYMENT IS TO BE MADE TO PROVIDER(S), SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge. X _____ Date Patient, or Parent if minor	AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S): I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization. X _____ Date Employee
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PROCEDURE FOR FILING A CLAIM

- Complete and sign the "Employee Statement" section of the form (Part #1).
 - It is important to know how, when and where your accident occurred.
 - Questions regarding other coverage you or your dependents are eligible for must be answered.
 - Patient, or parent if minor, must always sign the "Authorization to Release Information". A claim cannot be processed without this authorization and verification.
 - If payment is to be made to the provider of services, you should sign that section.
- Have your doctor or dentist complete the reverse side for each disability, diagnosis or treatment only when not accompanied by an itemized bill.
- If you have other coverage (including Medicare), make sure you attach all payment statements or declination letters.
- Attach all bills relating to the claim.
 - Make sure all bills identify the patient.
 - All bills should show the date of treatment, type of service, and amount of charges.

PART 2**TO BE COMPLETED BY PHYSICIAN**

PATIENT'S NAME		BIRTH DATE OF PATIENT	DOES PATIENT HAVE OTHER COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE IDENTIFY	
DIAGNOSIS AND CURRENT CONDITIONS					
HAS THE PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", WHEN AND DESCRIBE.					
REPORT OF SERVICES (IF PREVIOUS FORM SUBMITTED, YOU ONLY NEED DATES AND SERVICES SINCE LAST REPORT) OR ATTACH ITEMIZED BILL.				CLAIMS OFFICE USE ONLY	
DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE USED		CHARGES
_____	_____	_____	_____		_____
_____	_____	_____	_____		_____
_____	_____	_____	_____		_____
			TOTAL CHARGES	\$	
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION		AMOUNT PAID	\$	
IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		LAST DAY WORKED DATE	BALANCE DUE	\$	
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM _____ THROUGH _____		TYPE OR PRINT PHYSICIAN'S NAME	TAX ID NUMBER		
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK			SOCIAL SECURITY NUMBER		
DATE EMPLOYEE RETURNED TO WORK			(DIRECT PAYMENT CANNOT BE MADE IF NOT PROVIDED.)		
		CITY, STATE, ZIP CODE			
		PHONE	DEGREE		
PHYSICIAN'S SIGNATURE X _____					