



Insurance Claim Form (Medical /Vision)

P.O. BOX 71490 PHOENIX, AZ 85050
Phone: (888)419-1094 Fax: (623)889-7299

Instructions

- 1. Complete the front side of this form in full.
2. When the form is complete, send it along with the itemized hospital and medical bills to our office.
3. Do not complete a claim form with each bill you send.

Social Security Number Policy Number

1. Name of Policyowner Date of Birth Occupation

Address: Zip Code Phone:

Name and address of Employer

2. Patient's name, if other than policyowner Date of Birth Occupation Marital Status

Name and address of employer

3. Is patient covered by any other insurance? Yes No
If yes, give company name, address and policy number

4. If claim is due to an accident, how did it occur? Date of Accident

5. If claim is due to sickness, please describe

Date of first symptoms Date first treated

6. Name and Address of attending physician and hospital, if hospitalized

7. Has patient ever had a similar condition? Yes No
If yes, when and describe

8. If claim is for pregnancy, Date of delivery Name of Child

9. Did accident or sickness arise in the course of employment? Yes No

10. If person treated was disabled, please indicate:

- a) the first date patient could do no work because of sickness or injury Date: 20
b) the first date patient could resume some of his/her important duties Date: 20
c) the first date patient could resume all of his/her important duties Date: 20

I certify that the foregoing statements and answers are true and complete to the best of my knowledge and belief.
The furnishing of this blank is for the convenience of the policyowner and is not an acknowledgement of liability or waiver of any kind.

Authorization To Obtain Information

I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or employer, having information available as diagnosis, treatment and prognosis with respect to any physical or mental condition, treatment of me or my minor children to give Advanced Benefit Solutions LLC, or its legal representative, any and all such information.

I understand the information obtained by use of the authorization will be used by Advanced Benefit Solutions LLC, for claim purposes. Any information obtained will not be released by Advanced Benefit Solutions LLC, to any person or organization EXCEPT to reinsuring companies or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize.

I agree that a photocopy of this authorization will be as valid as the original.
I agree that this authorization will be valid for two years form the date shown below.

Patient's Signature: Date:

Policyowner's Signature: Date:

Continued on reverse side

To Be Completed By Patient (insured)

Patient's Name and Address _____ Date of Birth _____
 Insured's Name if patient is a dependent _____

Authorization to pay benefits to Physician: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or medical benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

Signed (Insured Person) _____ Date: _____

Attending Physician Statement

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA* used, give name): _____
2. Is condition due to injury or sickness arising out of patient's employment? Yes No
 Pregnancy? Yes No If yes, approximate date pregnancy commenced. Date: _____
3. Report of services or attach itemized bill. (If previous form submitted to this carrier, you need to show only dates and services since last report.)

Date of Services	Place of Services	Description of surgical or Medical services rendered	Procedure Code* If used (if code other than CPT** Give name)	Charges
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

O Doctor's Office	OH Outpatient Hospital	**CPT Current	Total Charges	\$ _____
IH Inpatient Hospital	OL Other locations	Procedural Terminology	Amount Paid	\$ _____
NH Nursing Home	*ICDA -International	(current edition)	Balance Due	\$ _____
H Patient's Home	Classification of Diseases			

4. Date symptoms first appeared or accident happened. _____
5. Date patient first consulted you for this condition. _____
6. Patient ever had same or similar condition? Yes No
7. Patient still under your care for this condition? Yes No
8. Patient was continually totally disabled (Unable to work). From _____ to _____
9. Patient was partially disabled. From _____ to _____
10. If still disabled, date patient should be able to return to work. From _____ to _____
11. Patient was house confined. From _____ to _____
12. Does Patient have other health coverage? Yes No
 If yes, please identify _____

13. I do not accept assignment
14. Social Security Number or Taxpayers Identification No. (required to be furnished under authority of law) _____
 Name of Clinic (Print) _____
 Date _____ Physicians Name (Print) _____ Signature _____
 Degree _____ Telephone (_____) _____
 Street Address _____
 City/Town _____ State _____ Zip Code _____