

QualChoice/QCA

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CLAIM FORM

THIS FORM MUST BE COMPLETED BY EMPLOYEE

EMPLOYEE / EMPLOYER INFORMATION

EMPLOYER NAME _____
EMPLOYEE NAME _____ I.D. NO: _____
DATE OF BIRTH _____ SEX _____
STREET ADDRESS _____
CITY & STATE _____ ZIP _____

I HEREBY PRESENT THIS CLAIM, and authorize any individual or organization to release information required for its acceptance.

1 CLAIM IS BEING MADE FOR:

- SELF UNMARRIED CHILD TO AGE 19
 WIFE / HUSBAND UNMARRIED FULL TIME STUDENT AGE 19 AND OVER, ATTENDING _____

2 PATIENTS NAME _____ DATE OF BIRTH _____ SEX _____

3 IS CLAIM DUE TO AN ACCIDENT? IF "YES", WHERE DID ACCIDENT OCCUR ? DATE OF ACCIDENT
 YES NO _____

DESCRIBE ACCIDENT:

4 IS THIS CLAIM THE RESULT OF A WORK RELATED ILLNESS OR INJURY ? YES NO IF YES, PLEASE FILE WITH WORKERS' COMPENSATION CARRIER FIRST.

5 IF MARRIED, IS YOUR WIFE/HUSBAND EMPLOYED?

YES NO

NAME _____

EMPLOYER _____

ADDRESS _____

5a IF CLAIM IS FOR A DEPENDENT CHILD, IS THIS CHILD EMPLOYED?

YES NO

EMPLOYER _____

ADDRESS _____

6 IS PATIENT ALSO COVERED FOR ANY OTHER INSURANCE BENEFIT AS LISTED BELOW, EITHER AS AN EMPLOYEE OR DEPENDENT?

YES NO

If Yes, check box below which applies and complete 6a

- Group health insurance of any kind including Blue Cross and Blue Shield
- Coverage of medical care expenses provided by an employer, a union welfare plan, any federal, state, provincial or other governmental program.
- Other arrangements of benefits for individuals of a group

6a GIVE NAME AND ADDRESS OF OTHER COMPANY OR ORGANIZATION PROVIDING INSURANCE:

NAME _____

ADDRESS _____

OTHER INSURANCE OR BLUE CROSS/BLUE SHIELD GROUP NO.(s) _____

7 EMPLOYEE'S SIGNATURE _____ SOC. SEC. NO. _____ DATE _____

COMMENTS: