



# GROUP MEDICAL PLAN CLAIM FORM

## EMPLOYEE AND PATIENT INFORMATION

<p>1. EMPLOYEE'S NAME _____</p> <p>2. EMPLOYEE'S ADDRESS _____ _____</p> <p>3. EMPLOYEE IS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED</p> <p>4. EMPLOYEE'S SSN or ID NUMBER _____</p> <p>5. EMPLOYEE'S EMPLOYER _____</p> <p>6. GROUP NUMBER _____</p> <p>7. PATIENT'S NAME (IF NOT EMPLOYEE) _____ RELATIONSHIP TO EMPLOYEE _____</p> <p>8. PATIENT'S ADDRESS (IF DIFFERENT FROM EMPLOYEE'S) _____</p> <p>9. PATIENT'S SSN or ID NUMBER _____</p> <p>10. PATIENT'S DATE OF BIRTH _____</p> <p>11. IS THIS CLAIM RELATED TO AN ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES: DATE OF ACCIDENT _____ TIME _____ <input type="checkbox"/> AM <input type="checkbox"/> PM DESCRIPTION (HOW AND WHERE) _____ _____</p> <p>12. IS THE PATIENT EMPLOYED, IF SO, WHERE _____</p>	<p>13. IS THIS CLAIM RELATED TO THE PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>14. DOES THE PATIENT HAVE ANY OTHER GROUP INSURANCE? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES: NAME OF INSURER _____ NAME OF EMPLOYER OR PLAN PROVIDING OTHER COVERAGE: _____ ADDRESS _____</p> <p>15. IS THE SPOUSE OF THE EMPLOYEE EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES: SPOUSE'S EMPLOYER _____ EMPLOYER'S ADDRESS _____</p> <p>16A. I HEREBY AUTHORIZE MY EMPLOYER, SELF FUNDING ADMINISTRATORS CORPORATION OR ANY OTHER ORGANIZATION PROVIDING BENEFITS OR SERVICES FOR MEDICAL TREATMENT AS WELL AS ANY DOCTOR, DENTIST OR HOSPITAL OR OTHER RELATED SERVICES TO RELEASE OR OBTAIN ANY INFORMATION NECESSARY TO DETERMINE THE BENEFITS PAYABLE UNDER THE PROGRAM OF THE GROUP BENEFITS ADMINISTERED BY SELF FUNDING ADMINISTRATORS CORPORATION AND HEREBY WAIVE THE PRIVILEGED CHARACTER OF SUCH INFORMATION. I CERTIFY THAT THE INFORMATION GIVEN BY ME IN SUPPORT OF THIS CLAIM IS TRUE AND CORRECT.  SIGNED (PATIENT OR PARENT IF PATIENT IS A MINOR) _____ DATE _____</p> <p>I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIERS FOR SERVICES DESCRIBED BELOW.</p> <p>16B. _____ SIGNED (EMPLOYEE OR SPOUSE) _____ DATE _____</p>
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## PHYSICIAN OR PROVIDER INFORMATION

17. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	18. DATE FIRST CONSULTED YOU FOR THIS CONDITION	19. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
20. DATE PATIENT ABLE TO RETURN TO WORK	21. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____
22. NAME OF REFERRING PHYSICIAN		23. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITAL DATES ADMITTED _____ DISCHARGED _____	
24. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		25. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO CHARGES _____	
26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE 1. _____ 2. _____ 3. _____			
27.	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. (Explain Unusual Services or Circumstances)	D	E
	PROCEDURE CODE (IDENTIFY)	DIAGNOSIS CODE	CHARGES
28. SIGNATURE OF PHYSICIAN OR SUPPLIER _____ SIGNED _____ DATE _____	29. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER.	30. TOTAL CHARGE	31. AMOUNT PAID
33. YOUR PATIENT'S ACCOUNT NUMBER			32. BALANCE DUE
		34. PHYSICIAN'S OR SUPPLIER'S NAME ADDRESS ZIP CODE & TELEPHONE NO.	

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|--------------------------------|-------------------------------|--------------------------------------|-------------------------------------|
| 1 - (IN) - INPATIENT HOSPITAL  | 4 - (H) - PATIENT'S HOME      | 7 - (NH) - NURSING HOME              | O - (OL) - OTHER LOCATIONS          |
| 2 - (HO) - OUTPATIENT HOSPITAL | 5 - DAYCARE FACILITY (PSY)    | 8 - (SNF) - SKILLED NURSING FACILITY | A - (IL) - INDEPENDENT LABORATORY   |
| 3 - (O) - DOCTOR'S OFFICE      | 6 - NIGHT CARE FACILITY (PSY) | 9 - AMBULANCE                        | B - OTHER MEDICAL/SURGICAL FACILITY |
- PLACE OF SERVICE CODES      • PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY

# HOW TO REQUEST MEDICAL PLAN BENEFITS

1. Each time you have a **different** accident or illness, please complete a **new** claim form and answer questions 1 through 16A on the reverse side of this form.

Please provide a **separate** claim form for **each** member of the family.

If you wish the benefits to be paid **directly** to your doctor or provider of service, please sign item 16B. If you wish the benefits to be paid to you, leave 16B blank.

2. Please attach completely itemized bills for each separate claim.

**ITEMIZED BILLS MUST INCLUDE:**

Doctor's Name and Tax ID Number  
Patient's Name  
Date of Service  
Condition Being Treated  
Charge for Service

3. If you do not have itemized bills, your doctor must complete the physician or provider of service information (items 17-34).
4. For your convenience, you may wish to accumulate small bills relating to the **same** claim and submit them on a monthly or quarterly basis.

**Send the request for benefits to:**  
Self Funding Administrators Corporation  
Claim Center  
Post Office Box 6596  
Annapolis, MD 21401

**If you have any questions, please call:**  
Annapolis Area  
(410) 757-4200  
Outside of the Annapolis Area  
800-424-8611