Allied Benefit Systems, Inc.
PO Box 909786-60690
Chicago, IL 60690
Phone: (800) 288-2078
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Medical Claim Form

Employer Information

Employer Name	Group Number

Employee Information

Employee Name			Birthdate
Social Security Number			
Employee Address	**City**	**State**	**Zip**

Do you or any of your dependents have other group medical coverage or Medicare?

[ ] Yes (please provide information below) [ ] No

Name of Individual with other coverage	Other Insurance Carrier or TPA		
Address of Carrier or TPA	**City**	**State**	**Zip**

Patient Information

Patient Name	Gender	Birthdate

Relationship to Employee

[ ] Self [ ] Spouse [ ] Child [ ] Other:

Claim Information

Was this claim due to an accident?	If yes, what was the date of the accident?
[ ] Yes [ ] No	
Where did the accident occur?	**Is this claim the result of a work related illness or injury?**
	[ ] Yes [ ] No

Provider Information

Provider Name	TIN	Patient Name	Date of Service	ICD 10 Code	CPT Code	Total Charge

Employee Authorization

AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the foregoing statements are true to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Allied Benefit Systems, Inc. and/or my employer any and all information with respect to any illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

Employee Signature _____ Date _____

Patient Signature _____ Date _____

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the provider of medical services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.

Employee Signature _____ Date _____

INSTRUCTIONS FOR FILING A MEDICAL CLAIM

COMPLETE EMPLOYEE'S STATEMENT: PLEASE BE SURE TO ANSWER EVERY QUESTION.

All bills must show the following information. Additional data will be requested if needed.

1) Confirmation of employee information
2) Confirmation of other insurance coverage
3) Confirmation of the patient information
4) Confirmation if the claim is related to an accident. If so, if the accident is work related.
5) Provider Name, Address and Tax ID
6) Date of Service
7) ICD Diagnosis Code(s) and Procedure Code(s)
8) Total Charge for Each Service
9) Sign and date the claim form.
10) Sign and date the Assignment of Benefits, if applicable.

If a claim is for prescription drugs, attach bills to form after completing "Employee's Statement of Claim" section. All bills must show: patient's name; prescription number; date(s) of purchase; and charge.

If claim is for registered nurses, x-ray, laboratory or medical equipment, attach bills to the form after completing "Employee's Statement of Claim" section.

Mail the claim form and the itemized bill to the address listed on the back of the Employee's ID card.

KEEP A COPY FOR YOUR RECORDS.

IMPORTANT ITEMS TO NOTE:

1) All charges must be submitted within the time frame specified in the summary plan description. Failure to do so will result in the denial of the charges.

2) From time to time, additional information may be requested in order to process a claim. Any additional information, i.e., other insurance payments, completed claim forms, subrogation forms, accident details, police reports, etc., must be submitted when requested. Failure to do so may result in the denial of the claim.

3) ALWAYS retain a copy for your records.