

MEDICAL CLAIM FORM



Employer Name:
Group Number:

A. EMPLOYEE INFORMATION

Alternate # or SSN: - -	Phone #: ()		
Last Name:	First Name:	MI:	Date of Birth: / /
Home Address:	New Address: Yes <input type="checkbox"/> No <input type="checkbox"/>		
City:	State:	Zip Code:	
Spouse Last Name:	First Name:	MI:	Spouse Date of Birth: / /

B. PATIENT INFORMATION

Last Name:	First Name:	MI:	Date of Birth:
Home Address:			
City:	State:	Zip Code:	
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Relation to Employee:	FT Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	School Phone#: ()

C. ACCIDENT INFORMATION

Work Accident: Yes <input type="checkbox"/> No <input type="checkbox"/>	Auto Accident: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Accident Occurred: / /
How did the accident occur?		

D. OTHER INSURANCE

Is the patient covered by another insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please complete the following:
Name of person carrying other insurance:	Date of Birth: / /
SSN: - -	Name of Other Insurance Carrier:
Policy Number:	Employer Name:
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.	
Employee Signature: _____	Date: _____

E. ASSIGNMENT OF BENEFITS

ALL BENEFIT PAYMENTS WILL BE ASSIGNED TO THE PROVIDER OF MEDICAL SERVICES.
Employee Signature: _____ Date: _____

F. PROCEDURE FOR FILING A CLAIM

- All claims should be filed within 90 days of the date of service.
- Complete ALL questions on form.
- Only submit ITEMIZED bills; (we cannot accept photocopies, balance due statements, or cash register receipts) Itemized statements must be signed by the provider of service and include patient's name, diagnosis, date of service, description of each service rendered, and amount charged for each service.
- Attach ORIGINAL bills to this claim form and mail to ADMINISTRATIVE ENTERPRISES, INC.
- Copy of this completed claim form can be used when submitting additional bills for the same injury or illness.
- Benefit payments are automatically assigned to your doctor or hospital. If you have made payment, be sure the bill is clearly marked as paid when submitting to AEI for processing.