

MedCost Benefit Services
P.O. Box 25987
Winston-Salem, NC 27114-5987
(336) 774-4400 Fax (336) 774-4420
1-800-795-1023



STATEMENT OF MEDICAL CLAIM

GROUP # _____

EMPLOYEE INFORMATION			
EMPLOYEE NAME (LAST, FIRST, MI)	MEMBER ID	DATE OF BIRTH / /	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
EMPLOYEE ADDRESS (CHECK HERE IF NEW ADDRESS <input type="checkbox"/>)	CITY	STATE	ZIP
		ARE YOU STILL EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/> IF "NO" DATE TERMINATED:	

SPOUSE INFORMATION			
SPOUSE NAME (LAST, FIRST, MI)	MEMBER ID	DATE OF BIRTH / /	
SPOUSE'S EMPLOYER'S NAME	ADDRESS	CITY	STATE ZIP

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED UNDER ANY OTHER MEDICAL PLAN? YES NO IF YES, PLEASE COMPLETE:

PARTICIPANT NAME _____ CARRIER NAME _____ GROUP # _____
CARRIER ADDRESS _____

PATIENT INFORMATION			
PATIENT NAME (LAST, FIRST, MI)	PATIENT RELATIONSHIP: SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER <input type="checkbox"/>		DATE OF BIRTH / /
IF DEPENDENT OVER AGE 19, COMPLETE	SCHOOL NAME	ADDRESS	PHONE
FULL TIME STUDENT INFORMATION:			
IF ACCIDENT, IS INJURY RELATED TO PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> OR AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>			
HOW, WHEN AND WHERE DID THE ACCIDENT HAPPEN?			
HAS PATIENT BEEN PREVIOUSLY TREATED FOR THIS CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/>			
IF YES, GIVE FIRST TREATMENT DATE:			

I authorize any physician, medical practitioner, hospital facility, consumer reporting agency, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my minor children to MedCost Benefit Services or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my minor children. I understand that MedCost Benefit Services will not release any information obtained by this authorization to any person or organization except reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully required or permitted, or as I may further authorize, I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be valid as the original. I agree that this authorization shall be valid for the duration of my claim.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Employee's Signature _____ Date _____

Patient's Signature _____ Date _____

I authorize payment of medical benefits directly to the providers of service.

Employee's Signature _____ Date _____

Provider of Service:
Please complete form or attach itemized bill.

↑ CARRIER
 ↓ PATIENT AND INSURED INFORMATION
 ↑ PHYSICIAN OR SUPPLIER INFORMATION
 ↓

HEALTH INSURANCE CLAIM FORM																																							
<div style="display: flex; justify-content: space-between;"> PICA <input type="checkbox"/> PICA <input type="checkbox"/> </div>																																							
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																																		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																													
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																													
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE																												
ZIP CODE			TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE			TELEPHONE (INCLUDE AREA CODE) ()																												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER																													
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>																													
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME																													
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME																													
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																													
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																													
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																													
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																													
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					23. PRIOR AUTHORIZATION NUMBER																																		
1. _____ 3. _____ 2. _____ 4. _____																																							
A		B		C		D		E		F		G		H		I		J		K																			
DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE																			
From	To																																						
MM	DD	YY	MM	DD	YY																																		
1																																							
2																																							
3																																							
4																																							
5																																							
6																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$														
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #																			
SIGNED _____										DATE _____										PIN# _____										GRP# _____									