

**STATEMENT OF CLAIM
GROUP HEALTH BENEFITS**

mail to: American Group Administrators, Inc., 101 Convention Center Dr., Ste. 200, Las Vegas, NV 89109
telephone: toll free: 800-842-4742; 893-3050

INSTRUCTIONS FOR FILING A CLAIM

YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.

BE SURE EVERY ENTRY ON THIS FORM HAS BEEN COMPLETED.

USE A SEPARATE FORM FOR EACH MEMBER OF THE FAMILY FOR EACH SEPARATE ILLNESS OR ACCIDENT.

ADDITIONAL BILLS FOR THE SAME PERSON MAY BE SUBMITTED COMPLETING ONLY THE EMPLOYEE SECTION OF THE CLAIM FORM.

FOR PHYSICIANS' CHARGES SEE INSTRUCTIONS ON REVERSE SIDE OF THIS FORM.

FOR DRUG CHARGES ASK FOR BILLS WHICH SHOW:

– Name of patient – name of physician prescribing medication – name of medication – prescription number and date filled.

RECEIPTS AND CANCELLED CHECKS ARE NOT ACCEPTABLE.

TO BE COMPLETED BY EMPLOYEE MEMBER

Plan/Employer: _____ Location: _____

Employee's Name _____ Date of Birth _____
month | day | year

SOCIAL SECURITY NO.

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 Employee's ID No. _____ Sex M F
(If other than Soc. Sec. No.)

Employee's Address _____
Street City State Zip

Is this a new address Yes As of what date _____ Telephone Number _____

Is this accident or sickness due to employment? Yes No Is employee married? Yes No

Name of Spouse _____ Is spouse employed? Yes No

Name and Address of Spouse's Employer _____

Patient's Name _____ Patient's Date of Birth _____
first middle initial last month day year

Patient's Relationship to Insured

Self	Spouse	Child	Other
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 If other indicated, please specify _____

If child, is she/he 19 years old or older? Yes No If yes, is she/he a full time student? Yes No

Name of School _____

IS THIS CLAIM BASED ON AN ACCIDENT? Yes No

If yes, give date _____ 19 ____ and Time _____ A.M. P.M.

Where did accident occur? _____

How did accident happen? _____

Have you or your dependent, or will you or your dependent, file claim for Worker's Compensation Benefits? Yes No

Are you or your dependent covered under another group insurance or government plan such as Medicare, an HMO plan, or automobile mandatory no-fault coverage, which will also cover for any of the medical expenses or disability losses of this claim? Yes No. If yes, give name of insurance company/first benefit insurer, organization or HMO providing benefits: _____

Name _____

Address _____ Policy No. _____

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning this claim, to American Group Administrators, Inc. for the purpose of validating and determining benefits payable in connection with this claim. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request.

Any person who knowingly and with intent to defraud files a statement containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent act, which is a crime punishable by law.

Patient's Signature (Parent or Guardian if claim is on a Minor) _____
Date



EMPLOYEE (MEMBER) INSTRUCTIONS FOR MEDICAL PROVIDER CLAIMS:

- ASK YOUR PRIMARY ATTENDING PHYSICIAN TO COMPLETE THIS FORM AND RETURN IT TO YOU
- ASK OTHER PROVIDERS OF SERVICE TO GIVE YOU AN ITEMIZED BILL WHICH INCLUDES
 - PATIENT'S NAME - NATURE OF ILLNESS OR INJURY - TYPE OF SERVICE - DATE OF SERVICE - CHARGE FOR EACH SERVICE OR SUPPLY - PROVIDER'S TELEPHONE NUMBER AND ADDRESS
- TO ASSIGN PAYMENT OF BENEFITS SIGN BELOW
- COMPLETE REVERSE SIDE OF THIS FORM

DO NOT SIGN UNLESS YOU DESIRE PAYMENT DIRECTLY TO SUPPLIER OF SERVICES

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize payment to the undersigned Physician of the Surgical and/or Medical Benefit, if any otherwise payable to me for the services as described below but not to exceed the reasonable and customary charge for those services.

(EMPLOYEE SIGNATURE)

PHYSICIAN OR SUPPLIER PLEASE COMPLETE IN FULL, INCLUDING YOUR PHONE NO.

PATIENT'S NAME (First name, middle initial, last name)	PATIENT'S DATE OF BIRTH	EMPLOYEE'S NAME (First name, middle initial, last name)
OTHER HEALTH BENEFIT PLAN - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number.	PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> Patient's relationship to employee Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	EMPLOYEE'S ADDRESS (Street, city, state, ZIP code)

Description of accident or sickness _____

Date of: Illness (first symptom) _____ Injury (accident) _____ Pregnancy (LMP) _____

IS CONDITION RELATED TO Patient's Employment? An Auto Accident?	NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)		
Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>			
Last day worked	Date able to return to work	Date Patient first consulted you for this condition	Has Patient ever had same or similar symptoms? Yes <input type="checkbox"/> No <input type="checkbox"/>
Name & Address of Referring Physician	Dates of total disability From _____ Through _____	Dates of partial disability From _____ Through _____	
		For services related to hospitalization give hospitalization dates Admitted _____ Discharged _____	

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.
- 4.

A DATE OF SERVICE	B* Place of Service	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN.		D Diagnosis Code	E CHARGES
		Procedure Code (Identify:)	(Explain unusual services or circumstances)		

SIGNATURE OF PHYSICIAN OR SUPPLIER	Please complete one tax identification number:	TOTAL CHARGE	
	Your Social Security No.	AMOUNT PAID	Physician's Telephone No.
	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE	Your Employer ID No.	BALANCE DUE

- *PLACE OF SERVICE CODES
- | | | | |
|--------------------------------|-------------------------------|--------------------------------------|-------------------------------------|
| 1 - (IH) - Inpatient Hospital | 4 - (H) - Patient's Home | 7 - (NH) - Nursing Home | 0 - (OL) - Other Locations |
| 2 - (OH) - Outpatient Hospital | 5 - Day Care 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 |