

# GROUP HEALTH CLAIM FORM

POLICY NUMBER \_\_\_\_\_ NAME OF EMPLOYER \_\_\_\_\_

## EMPLOYEE'S STATEMENT: TO BE COMPLETED BY THE COVERED EMPLOYEE

Name of employee \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Marital status:  SINGLE  MARRIED  WIDOWED  LEGALLY SEPERATED

Mailing Address: \_\_\_\_\_

Name of Employee's spouse \_\_\_\_\_ Spouse's date of birth \_\_\_\_\_

Does spouse's employer provide a group insurance plan?  YES  NO

If yes, is the patient for this claim covered by that plan?  YES  NO

Patient's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

If child is the patient, is child a full time student?  YES  NO Is child employed?  YES  NO

Name of School or Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tuition Paid Thru: \_\_\_\_\_ Number of Credit Hours \_\_\_\_\_

## COMPLETE FOR INJURY:

Where did injury occur? \_\_\_\_\_ How did it happen? \_\_\_\_\_

Was the accident connected with the patient's employment?  YES  NO Auto accident?  Yes  NO

Date of accident \_\_\_\_\_ Any other insurance involved?  YES  NO

If so, name, address, policy # of other company \_\_\_\_\_

## COMPLETE FOR COORDINATION OF BENEFITS:

Is the above named patient covered under any other insurance which provides benefits for hospital, surgical, or medical treatment  YES  NO

If yes, please provide name, address and policy # of other insurance company: \_\_\_\_\_

## AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE the disclosure of relevant information about me for the purpose of evaluating and administering my claim.

I AUTHORIZE the following to disclose such information: any physician, medical professional, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, consumer reporting agency, medical or hospital service, prepaid health plan, employer, group policyholder, contract holder or benefit plan administrator. They may disclose such information to D. Edward Wright, Inc., insurers and/or reinsures and any benefit plan administrator, consumer reporting agency, agent or independent claim administrator acting on its behalf.

I UNDERSTAND that relevant information for claims purposes includes employment related information and information about medical care, advice diagnoses, treatment, supplies provided, mental illness, and drug or alcohol abuse.

I UNDERSTAND that D. Edward Wright, Inc. will not release this information EXCEPT to insurance companies and/or reinsuring companies, to other persons or organizations performing business or legal services in connection with my claim, or as the law otherwise requires or permits.

I KNOW that I may receive a copy of this Authorization upon request.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be vail as follows:

- (1) for claims of Health Insurance Benefits, for one year from the date shown below or for the term of coverage and the policy, whichever is shorter, or
- (2) for all other Claims, for one year from the date shown below or for the duration of the clam, whichever is shorter.

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

Name of claimant \_\_\_\_\_ Relationship of authorized person to claimant \_\_\_\_\_

Signature of claimant or authorized person \_\_\_\_\_

## SUBMIT COMPLETED FORM TO:

**IntraHealth Solutions, Inc.**

**111 E. Ludwig Road, Suite 108**

**Fort Wayne, IN 46825**

(260) 969-4010

Toll Free: 877-755-4010