

CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO _____

FOR PROMPT PAYMENT
COMPLETE REVERSE SIDE



Pursuant to Section 817.234, FLORIDA Statutes...Any person who knowingly and with intent to injure defraud, or deceive any employer or employee, Insurance Company or self-insured program, files a statement of claim containing false or misleading information is guilty of a felony of the third degree.

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www.firstbenefitadmin.com

GROUP NO.

**PART 1 MUST BE COMPLETED BY EMPLOYEE
(Please Print)**

Employee Name		Date of Birth	Employer Name		FBA or Medical ID Number
Address: Number and Street		City	State	Zip Code	Phone: Work Home
Dependent Name (If Patient)	Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		If over 19 & full time student / Name of School		Date of Birth
Date Injury or Sickness Began	Is Claim Being Made For Workman's Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No		Physician Name		
Nature of Sickness, Injury, Diagnosis or Medical Call					
If injured, How, When and Where Did Accident happen?					
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse Name		Name and Address of Spouse Employer (If not Employed Write "Not Employed")	
Are you or your dependent covered under any other Group Insurance, Health Maintenance Organization, Federal Plan or Union Welfare Plan which may also pay for any of the expenses of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, complete all information below:					
Name and Address of Ins. Co.		Policy / Contract #	Name of Policyholder	Parties Covered under Plan	Effective Date
IF PAYMENT IS TO BE MADE TO PHYSICIAN SIGN BELOW			PATIENT OR PARENT MUST SIGN BELOW		
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I hereby authorize payment directly to the undersigned Physician, otherwise payable to me for his services, but not to exceed the reasonable and customary charge for those services or the contracted network fees.			AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize any Physician to release any information acquired in the course of my examination or treatment.		
SIGNED (Patient or Parent) Sign Only If Payment is to Go to Doctor.			SIGNED (Patient or Parent if Minor)		
X _____ Date			X _____ Date		

**PART 2 MUST BE COMPLETED BY PHYSICIAN
(Please Print)**

Patient Name		Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Patient Date of Birth Mo Day Year		Full-Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No Name of School			
Employee Name First Middle Last						FBA or Medical Plan #					
Employee Mailing Address						Employer (Company) Name and Address					
City			State		Zip Code						
Are Other Family Members Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Employee Name Soc. Sec. No.				Name and Address of their Employer							
Is Patient Covered by Another Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			Group No.		Name and Address of Carrier						
Diagnosis and Concurrent Conditions (If Diagnosis Code Other Than ICD9* Use Diagnosis Name)											
Is Condition Due to Injury or Sickness Arising Out of Patient's Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No				Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Approximate Date Pregnancy Commenced:			Date		
Report of Services (or Attached Itemized Bill)											
Date of Services		Place of Services		Description of Surgical or Medical Services Rendered			Procedure Code If Used (IF CODE OTHER THAN CPT Used Give Name)		Charges	Claims Office Use Only	
_____		_____		_____			_____		_____	_____	
_____		_____		_____			_____		_____	_____	
_____		_____		_____			_____		_____	_____	
_____		_____		_____			_____		_____	_____	
							TOTAL CHARGES		\$		
							AMOUNT PAID		\$		
							BALANCE DUE		\$		
Was Patient Referred? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, by whom?											
Date Symptoms First Appeared or Accident Happened				Date Patient First Consulted You for This Condition			Is Patient Still Under Your Care for This Condition? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Has Patient Ever Had Same or Similar Condition? If "Yes" When and Describe				<input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Was Continuously Totally Disabled (Unable To Work) From: Thru:					
Date Last Worked			Date Employee Returned to Work:			If Still Disabled, Date Patient Should Be Able To Return To Work					
Physician Name (Print)						License # / Degree					
Mailing Address						City		State		Zip Code	
Telephone			Fax			E-mail					
Signature						Date		SS# or TIN#			
X											

INSTRUCTIONS FOR FILING

1. Complete the employee's portion – Part 1
2. Have your Physician complete the Attending Physician Statement – Part 2
3. Have your Physician return the form to you or forward to Florida Benefit Administrators