

1 - MEMBER/PATIENT	Member Name: (First, Middle, Last)		Member Number:		Group Number:		
	Address: <i>Is this a New Address?</i> <input type="checkbox"/> Y <input type="checkbox"/> N		City		State	Zip Code	
	Patient Name: (First, Middle, Last)		Patient's relationship to member:			Sex:	
			<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Handicapped Dependent <input type="checkbox"/> Other			<input type="checkbox"/> M <input type="checkbox"/> F	
Does the patient have other health insurance coverage? <input type="checkbox"/> Y <input type="checkbox"/> N If Yes, please complete section 2.							

2 - OTHER INSURANCE	Policyholder's Name: (First, Middle, Last)		Birth Date:	Policyholder's Member Number	Effective Date:	
	Other Insurance carrier's information:					
	Insurance Name:		Address:			
	City		State	Zip Code	Phone Number:	
					()	
	Policyholder's employment status:				Patient's relationship to member:	
	<input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Effective Date: ___/___/___				<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
	Type(s) of Coverage: (Check all that apply)					
	<input type="checkbox"/> Hospitalization <input type="checkbox"/> Medical-surgical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug <input type="checkbox"/> Major Medical <input type="checkbox"/> Other(Specify): _____					
	Coverage Covers: (Check all that apply)					
<input type="checkbox"/> Policyholder only <input type="checkbox"/> Policyholder and spouse <input type="checkbox"/> Policyholder and child(ren) <input type="checkbox"/> Family						
Is the patient entitled to benefits under Medicare Part A or B?			<input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, complete the rest of section 2.	
Medicare effective date: ___/___/___			Medicare ID#:			
Member's employment status			<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled			

3 - PATIENT CONDITION	Please provide description of services, as well as diagnosis. (Include valid ICD diagnosis and CPT codes)		Name of doctor treating injury/illness (Tax ID Number must be provided)		Date of Symptoms	
	(A)				___/___/___	
					___/___/___	
	(B) If this claim is the result of an injury, do you intend to file a claim against another individual, business, organization or insurer for damages arising from the injury: <input type="checkbox"/> Yes <input type="checkbox"/> No					
	(C) If this claim is the result of an injury, have you retained an attorney to represent you?: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the rest of question 3C.					
	Attorney Name:		Address:			
	City		State	Zip Code	Phone Number:	
					()	
	(D) Were the services related to a hospitalization?			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the rest of the question 3D.		
	Admission Date: ___/___/___			Discharge Date: ___/___/___		
(E) Were the expenses due to an accident?			<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, complete the rest of the question 3E.			
Accident Date: ___/___/___ <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> School <input type="checkbox"/> Other (Specify) _____						

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits actually incurred by the named patient. I authorized any hospital, physician, or other provider who participated in the care and treatment of the patient to release all medical or other information requested for the processing of the claim to First Choice Health Administrators. I hereby agree to reimburse First Choice Health Administrators in full if this claim is paid incorrectly. 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Member Signature

Date

(Area Code) Home Phone

(Area Code) Home Phone