

EMPLOYEE'S NAME _____	EMPLOYER _____	MEMBER ID # _____
HOME ADDRESS Street _____		
City _____ State _____ Zip _____		
Phone No. _____ Work No. _____		
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		
PATIENT'S NAME _____	DATE OF BIRTH _____	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		
If patient is a child over 19, is the child of a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give expected date of graduation ____/____/____ Give name and address of school/college: _____	If patient is a dependent child, are these parents divorced or separated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information: (1) Who has primary custody of this dependent? <input type="checkbox"/> Natural Mother <input type="checkbox"/> Natural Father <input type="checkbox"/> Other (2) Is there a legal document directing either parent to provide insurance coverage for this dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No Which parent? <b>Please attach a copy of this document if not previously provided.</b>	
Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, please provide Employer Name, Address & Phone: Employer _____ Street _____ City _____ State _____ Zip _____ Phone No. _____		
is this claim covered under any other Group Insurance or any Medical Plan because of membership in a group? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name and Address of Employer, Union, Insurance Company, or Government Agency: Name of Insurer _____ Effective Date _____ Address _____ Type of Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Other   Policy No. _____		
If eligible, is patient enrolled in Federal Medicare? Part A: <input type="checkbox"/> Yes <input type="checkbox"/> No   Effective Date _____ Part B: <input type="checkbox"/> Yes <input type="checkbox"/> No   Effective Date _____		
Were expenses due to an accidental injury? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, (1) Give date of accident ____/____/____ Give type/place of accident <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Auto <input type="checkbox"/> Motorcycle <input type="checkbox"/> Other _____ (2) Give brief description of accident _____ _____ (3) Has claim been or will claim be filed under any Workers' Compensation Act? <input type="checkbox"/> Yes <input type="checkbox"/> No (4) Has claim been or will claim be filed against any other person or company liable for the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		
I hereby direct payment be made to: <input type="checkbox"/> My Provider <input type="checkbox"/> Myself Signature _____ Date _____		

**IMPORTANT: THE FOLLOWING AUTHORIZATION MUST ALSO BE COMPLETED**

To all physicians, hospital, medical service providers, druggists, employers and any other agencies or organizations (including other insurance companies, Blue Cross/Blue shield and prepaid health plans).

For purposes of evaluating a claim, you are authorized to permit Spectrum Administrators, Inc. to view or obtain a copy of all existing records (including those of psychiatric, drug or alcohol treatment) pertaining to the examination, medical and dental treatment, history, prescriptions, employment and insurance coverage) of:

\_\_\_\_\_ PRINT NAME OF PATIENT

This information is for the sole use of Spectrum Administrator's employees who are involved in processing the claim and will not be furnished in any identifiable form to any other persons without my written consent unless expressly permitted or required by law. I understand that this authorization will be valid for the Plan Year beginning January 1, 20\_\_\_\_, and will remain in effect until the end of that year.

I agree that a photographic copy of this authorization will be as valid as the original. Anyone signing this authorization may have a copy of it, upon request. I certify that the above information and attachments, in any, are accurate.

DATE: \_\_\_\_\_, 20\_\_\_\_ SIGNED: \_\_\_\_\_

PATIENT, IF OTHER THAN EMPLOYEE

DATE: \_\_\_\_\_, 20\_\_\_\_ SIGNED: \_\_\_\_\_

EMPLOYEE

**ATTENDING PHYSICIAN'S STATEMENT**

Diagnosis and Concurrent Conditions (if diagnosis code other than ICDA\* used, give name)\_\_\_\_\_

Is condition due to injury or sickness arising out of patient's employment?      Yes      No

Report of Services (or attach itemized bill - if previous form submitted to this carrier, you need show only dates and services since last report.)

DATES OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE - (IF CODE OTHER THAN CPT** USED, GIVE NAME)	CHARGES

\* ICDA - International Classification of Diseases  
 \*\*CPT - Current Procedural Terminology (current edition)

Total Charges	\$
Amount Paid	\$
Balance Due	\$

Date symptoms first appeared or accident happened:

Date patient first consulted you for this condition:

Patient ever had same or similar condition?     Yes     No    If yes, when and describe? \_\_\_\_\_

Signature of Physician or Supplier  
 Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's/Supplier's Name, Address and Telephone Number

Patient's Account No.

Physician's Tax I.D. No.

Place of Service Codes

- |                            |                               |                                  |                               |
|----------------------------|-------------------------------|----------------------------------|-------------------------------|
| 1-(IH)-Inpatient Hospital  | 4-(H)-Patient's Home          | 7-(NH)-Nursing Home              | O-(OL)-Other Locations        |
| 2-(PJ)-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    |

