COUNTY OF MONMOUTH

Self Funded Insurance Plan

HEALTH CLAIM FORM

INSTRUCTIONS

1. Answer every question within the Employee's Statement, Part A.
2. Sign the Employee's Statement, Part A, under Authorization to Release Information.
3. Have your physician either (a) complete the Physician's Statement, Part B, on the back of this form, or (b) provide you with his/her own insurance form.
4. Attach all bills, including hospital bills, for charges that you refer to on this claim form. These bills must identify the patient's name, conditions treated (diagnosis), type of treatment, date each expense was incurred, and itemized charges.
5. Mail this form and the attached bills to: Insurance Administrator of America, Inc.
   PO Box 5082
   Mt. Laurel, NJ 08054 FAX CLAIMS TO: 1-800-238-0519

FULLY COMPLETE FOR ALL CLAIMS

Employee's Name (Please Print)	Group Number # 9992	Your Date of Birth	Social Security No.

Address: Street and No. City State Zip Code

Phone Number

This claim is on:
[ ] Myself [ ] Spouse [ ] Dependent Child

Are you, or your spouse covered under another Plan? [ ] Yes [ ] No

If Spouse is employed, His or Her name _____and Soc. Sec. No. _____
Name, address & phone number of company where he/she is employed:

Company Name _____

Address _____Telephone No._____

What was the sickness or injury?	On what day did it begin?	Date of first expense for condition:

Are Benefits payable from any other source (including Military, Automobile, Liability Insurance, School Accident Insurance) for the Expenses submitted?
[ ] Yes [ ] No

If "Yes", (a) Other Source _____
(b) Address: _____
(c) Policy No. or ID No. _____

COMPLETE FOR ALL INJURIES

Date of Injury?	Where did injury occur?	How did the injury occur?

Did this condition arise from:
____ Work related accident/incident ____Auto accident ____ Fire
____ Slip, trip or fall ____Defective product ____Chemical substance exposure
____ Improper medical care ____Athletic activity/sport ____ Natural substance/allergy
____ Intentional act of another/assault ____ Intentional act of patient ____ Accident/incident not related to work

Please explain:

Has or will claim be filed under any Workmen's Compensation Act or similar law? [ ] Yes [ ] No

COMPLETE ONLY FOR DEPENDENT CLAIMS

Name of Dependent	Date of Birth	Relationship to Employee	[ ] Married [ ] Single

If employed or attending school, give the name of employer or school: Name
_____

I authorize any physician, medical practitioner, hospital, clinic or other health facility consumer reporting agency, the Medical Information Bureau, insurance/reinsurance company or employer to release any and all medical and non-medical information in its possession about me or my dependents to Insurance Administrator of America, Inc. or its legal representative. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my dependents. I understand that Insurance Administrator of American, Inc. will use the information obtained by this authorization to determine eligibility for insurance and eligibility for benefits under an existing plan. Insurance Administrator of America, Inc. will not release any information obtained by this authorization to any person or organization except insurance/reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully required or permitted, or as I may further authorize. I know that I may request and receive a copy of this authorization. I agree that this authorization shall be valid for the duration of my claim.

_____ _____
Employee and Patient (Parent if minor) Date

FLEXIBLE SPENDING ACCOUNT

I request reimbursement for any allowable charges on this claim which are considered but not fully paid by the group medical plan. I verify that such expense(s) requested here have not been reimbursed and are reimbursable under any other health coverage. I further verify that the attached expenses are eligible for reimbursement form my Flexible Spending Account and that they qualify as deductions as outlined by the Internal Revenue Code

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME: (First, M.I., Last)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First, M.I., Last)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)	5. PATIENT'S SEX M ☐ F ☐ 7. RELATIONSHIP TO INSURED SELF ☐ SP ☐ CH ☐ OTHER ☐	6. INSURED'S ID, MEDICARE, AND/OR MEDICAID# 8. INSURED'S GROUP # OR NAME
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder, Plan Name, Address and Policy or Medical Assistance Number	10. WAS CONDITION RELEATED TO A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO B. AN ACCIDENT YES ☐ ☐ NO	11. INSURED'S ADDRESS (Street,City,State,Zip Code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical information necessary to process the claim and request payment of benefits Signed Dated		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW Signed (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF:	ILLNESS (FIRST SYMPTOM OR INJURY ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMLAR SYMPTOMS YES ☐ NO ☐	16A. IF AN EMERGENCY CHECK HERE
17. DATE PATIENT WAS ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH	
19. NAME OF REFERRING PHYICIAN OR OTHER SOURCE (e.g. public health agency)			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES ☐ NO ☐ CHARGES	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATED DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFFERENCE NUMBERS 1,2,3, ETC OR DX CODE A. 1. 2. 3. 4.			B. EPSDT YES ☐ NO ☐ FAMILY PLANNING YES ☐ NO ☐ PRIOR AUTHORIZATION	

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE	(Explain Unusual Services or Circumstances)	D. DX CODE	E. CHARGES		F. DAYS/ UNITS	G. T.O.S.	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	26. ACCEPT ASSIGNMENT YES ☐ NO ☐ 30. YOUR SOCIAL SECURITY NUMBER	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
		31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE		
32. YOUR PATIENT'S ACCOUNT NUMBER	33. YOUR EMPLOYER ID NUMBER	ID NUMBER		