MEDICAL CLAIM FORM

HealthCare SOLUTIONS GROUP
P.O. Box 1309 ● Muskogee, OK 74402
1-800-749-1422

Name of Employer _____ Group Number _____

Medical bills must show:	Drugs:
Patients Name	Rx # & Doctor
Date & Diagnosis	Drug Name
Procedure & Charge	Amount $

ANSWER ALL QUESTIONS BELOW:

PART 1 – EMPLOYEE INFORMATION

Name: **First** **Middle** **Last** **Soc. Sec. No.** ☐ **Male** ☐ **Female** **Date of Birth**

Home Address **City** **State** **Zip Code**

PART 2 – PATIENT INFORMATION

Patient's Name **Relationship** **Date of Birth** **age 19 or over must state school attending and provide verification**

PART 3 – COORDINATION OF BENEFITS INFORMATION

Does patient have other insurance coverage? ☐ **Yes** ☐ **No**

If yes, Name of Insured **Relationship to patient**

Name of other insurance plan **Policy #**

Soc. Sec. No.

Employer

PART 4 – COMPLETE THIS SECTION IF CLAIM IS A RESULT OF ANY ACCIDENTAL INJURY

When did accident happen: **Where did accident happen?**

Mo. **Day** **Yr.** **Did accident happen at work?** ☐ **Yes** ☐ **No**

Give a brief description of the accent:

MEDICAL AUTHORIZATION

FOR CLAIM EVALUATION PURPOSES, I HEREBY AUTHORIZE ANY MEDICAL PRACTIONER, HOSPITAL , CLINIC OR OTHER HEALTH CARE PROVIDER OR ANY INSURER OR OTHER HEALTH CARE COVERAGE PROVIDER, WITH MEDICAL INFORMATION INCLUDING INFORMATION ABOUT DIAGNOSIS, TREATMENT, EXAMINATION OR PROGNOSIS AND INCLUDING PSYCHIATRIC AND DRUG OR ALCOHOL ABUSE INFORMATION, TO GIVE THIS INFORMATION TO HEALTHCARE SOLUTIONS GROUP AND ITS AUTHORIZED RESPRESENTATIVES FOR CLAIM EVALUATION PURPOSES INCLUDING CLAIM VERIFICATION AND REVIEW PURPOSES. THIS INFORMATION MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESCENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). I ALSO AUTHORIZE HEALTHCARE SOLUTIONS GROUP AND ITS AUTHORIZED REPRESENTATIVES TO GIVE THE ABOVE INFORMATION TO A REINSURER OR OTHER INSURER OR ORGANIZATION PROVIDING COVERAGE WITH RESPECT TO THE CLAIM, OR TO THE POLICY HOLDER OR POLICY ADMINISTRATIOR, OR TO THEIR AUTHORIZED REPRESENTATIVES. I UNDERSTAND THAT THIS AUTHORIZATION WILL BE VALID UNTIL FINAL DISPOSITION OF THE CLAIM , UNLESS I REVOKE THIS AUTHORIZATION UPON WRITTEN REQUEST. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL. ANY PERSON WHO KNOWLINGLY 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 FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

EMPLOYEE SIGNATURE _____ **SPOUSE SIGNATURE** _____ **DATE** _____

ASSIGNMENT: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDERS OF ATTACHED SERVICES FOR THE MEDICAL BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES DESCRIBED HEREIN, BUT NOT TO EXCEED THE USUAL AND CUSTOMARY CHARGE FOR THOSE SERVICES. I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT.

EMPLOYEE SIGNATURE _____ **SPOUSE SIGNATURE** _____ **DATE** _____