

EMPLOYER _____

CLAIM NO. _____



**ISLAND GROUP ADMINISTRATION, INC.
HEALTH BENEFIT CLAIM FORM
3 TOILSOME LANE, EAST HAMPTON, NY 11937-6046
LOCAL (631) 324-2306 / OUT OF AREA (800) 926-2306**

*** TO BE COMPLETED BY EMPLOYEE ***

EMPLOYEE SOCIAL SECURITY # _____ - _____ - _____

EMPLOYEE'S NAME _____

EMPLOYEE'S ADDRESS _____

EMPLOYEE'S PHONE # (HOME) _____ (WORK) _____

1. Patient's Name: _____

2. Patient's Address: _____

street

city

state

zip

3. Patient's Date of Birth: _____ Sex: MALE FEMALE

4. Patient's relationship to employee: SELF SPOUSE CHILD OTHER

5. Was condition related to: (A) PATIENT'S EMPLOYMENT YES NO

(B) AUTOMOBILE ACCIDENT YES NO

(C) OTHER YES NO

6. IF YOU ANSWERED YES TO #5 A, B or C, answer the following:

A. When did the accident occur? _____, 19____ AT _____ A.M./P.M.

B. Where did the accident happen? _____

C. Brief description of accident _____

7. Is patient covered by other health insurance? YES NO

8. Name of other health plan _____

9. Is patient covered by MEDICARE or MEDICAID? YES NO

*** DEPENDENT INFORMATION ***

IF PATIENT IS A STUDENT OVER AGE 19, PLEASE ANSWER THE FOLLOWING:

1. Name of school and date enrolled _____

2. Except for regular vacation periods, was student enrolled during the entire period covered by this claim? YES NO

3. Have you provided a TUITION STATEMENT for the period covered by this claim? YES NO

IF NO, PLEASE ATTACH THE TUITION STATEMENT TO THIS CLAIM FORM.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM

SIGNATURE OF EMPLOYEE OR GUARDIAN

DATE

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN OR SUPPLIER OF SERVICES: YES NO

SIGNATURE OF EMPLOYEE OR GUARDIAN

DATE

***ATTACH A COMPLETE PHYSICIAN/HOSPITAL BILLING TO THIS CLAIM FORM OR HAVE A PHYSICIAN COMPLETE BACK OF THIS CLAIM FORM.**

*** TO BE COMPLETED BY PHYSICIAN OR SUPPLIER *
IN ABSENCE OF COMPLETED BILLING**

1. Patient's Name: _____
2. _____

A Date of Svc.	B Place of Svc.	C Fully describe procedures, medical services or supplies; furnished for each date given	D Diagnosis Code	E Charges	F
		Procedure Code (Identify: _____) (Explain unusual services or circumstances)			

3. Date first consulted for this condition _____
 4. Has patient ever had same/similar symptoms? YES NO
 5. Was laboratory work performed outside your office? YES NO
 6. Dates of total disability: from _____ through _____
 7. Date patient able to return to work? _____
 8. For services related to hospitalization:
 Date Admitted _____ Date Discharged _____
 9. Name of referring physician _____
 10. Accept assignment YES NO
 11. Patient's Account Number _____
 12. TOTAL CHARGES \$ _____ AMOUNT PAID \$ _____ BALANCE DUE \$ _____
 Physician/Supplier Name _____
 Physician/Supplier Tax I.D. # _____
 Physician/Supplier Phone # (_____) _____
 Physician/Supplier Address _____

**SEND THIS COMPLETED FORM AND A COPY OF THE BILL TO:
 ISLAND GROUP ADMINISTRATION, INC.
 3 TOILSOME LANE
 EAST HAMPTON, NY 11937-6046**

