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 CLAIM FORM AND A COPY OF THE BILL TO:

ISLAND GROUP ADMINISTRATION, INC.
3 TOILSOME LANE
EAST HAMPTON, NY 11937-6046