

**STATEMENT OF CLAIM FOR  
GROUP MEDICAL EXPENSE BENEFITS**

**FORWARD COMPLETED CLAIM FORMS TO:  
EQUITABLE PLAN SERVICES**

P.O. BOX 720460  
OKLAHOMA CITY, OK 73172-0460  
(405) 755-2929

Company certifies employee is a member of Group Health Plan.

**EQUITABLE PLAN SERVICES, INC.**

**HOW TO CLAIM:** COMPLETE THIS SIDE OF FORM AND TOP PORTION OF REVERSE SIDE FOR ASSIGNMENT OF BENEFITS.

HAVE THE ATTENDING PHYSICIAN COMPLETE HIS PORTION OF REVERSE SIDE IF YOU DO NOT HAVE BILLING.

**INCOMPLETE ANSWERS MAY DELAY PROCESSING.**

Signed \_\_\_\_\_

Effective coverage date of Claimant \_\_\_\_\_

Termination date of coverage \_\_\_\_\_

<b>NAME AND ADDRESS OF EMPLOYER</b>	_____	Group # _____
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<b>ABOUT YOU</b>	Name and Address of Employee _____ Social Security # _____ _____ _____	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated
		Date of Birth _____ / _____ / _____

<b>ABOUT YOUR SPOUSE</b>	Name of Spouse _____ Is Spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Does Spouse's Employer Provide Group Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Your Spouse Covered By That Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name & Address of Spouse's Employer _____ _____
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<b>ABOUT THE PATIENT</b>	<b>This Claim is For:</b> <input type="checkbox"/> Myself - if disabled, 1st day not worked ____ / ____ / ____      Return      Expected <input type="checkbox"/> My Spouse _____      Date of Birth ____ / ____ / ____ <input type="checkbox"/> My Child - Name _____      Date of Birth ____ / ____ / ____		Is Child Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer or School Name, City, State _____ If Over 19 Years of Age, is Child A Full Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No Income Tax Exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>ABOUT THE CLAIM</b>	This Claim is Due to: (complete question 1 and either 2A or 2B) 1. Is this condition related to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No 2A. <b>AN ACCIDENT</b> Nature of Injury? _____ How Did It Happen? _____ _____ Where? _____      When? ____ / ____ / ____ When Was A Physician first consulted? ____ / ____ / ____	
	2B. <b>An Illness</b> Name of Illness? _____ When Did Symptoms Begin? ____ / ____ / ____ When was A Physician first consulted? ____ / ____ / ____ Have you seen any other Physician within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Physician: _____      Address: _____	

<b>ABOUT OTHER INSURANCE</b>	Is The Patient Covered By One or More of the Following? Any other group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No      Any individual Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Any federal, state or other government plan, or union welfare plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Any medical plan sponsored by a school or college? <input type="checkbox"/> Yes <input type="checkbox"/> No Any auto insurance if any injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If "Yes" To Any of the Above, Name and Address of other Insurance Company _____	Name of Insured _____ Policy No. Of Certificate No. _____	Name and Address of Employer, Group or School Providing The Plan _____

IF WEEKLY INCOME BENEFITS ARE INCLUDED, THIS AREA IS TO BE COMPLETED BY YOUR EMPLOYER UNLESS SPECIAL FORM USE.

1. Current basic weekly earnings (exclusive of bonus and overtime) \$ \_\_\_\_\_      3. Is this disability due to employment? \_\_\_\_\_  
 2. Date last worked \_\_\_\_\_ 19 \_\_\_\_\_      4. Date employee returned (or is expected to return to work) \_\_\_\_\_

Signed in behalf of Employer by \_\_\_\_\_      Date \_\_\_\_\_ 19 \_\_\_\_\_

**OK: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**KY: WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person filed a statement of claim containing any materially false information or conceals for purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**CERTIFICATION & AUTHORIZATION (to be signed by the patient [or parent if patient is a minor] and the certificate holder)**

I hereby certify that the above answers and statements, hereon and attached, are to the best of my belief, accurate. I hereby authorize any hospital, physician, or other insurance company to furnish EQUITABLE PLAN SERVICES, INC. Or its representative, or permit said company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital medical records or other company records. A photocopy of this authorization shall be considered as valid as the original.

Date X	Patient Signature X	Certificate Holder Signature X
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**ASSIGNMENT OF BENEFITS**

**PAYMENT TO HOSPITAL** I hereby direct that all hospital benefits due me be paid directly to the hospital rendering treatment.  
Signature of Insured Person \_\_\_\_\_

**PAYMENT TO PHYSICIAN** I hereby direct that all medical or surgical benefits be paid directly to the physicians rendering service.  
Signature of Insured Person \_\_\_\_\_

**PAYMENT TO EMPLOYEE** Please reimburse em for benefits due and I understand that I am financially responsible fro any expenses due the providers of services.  
Signature of Insured Person \_\_\_\_\_

**WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**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 similar symptoms? \_\_\_\_\_  Yes \_\_\_\_\_  No

17. Date patient able to return to work \_\_\_\_\_  
18. Date of total disability From \_\_\_\_\_ Through \_\_\_\_\_  
Date of partial disability From \_\_\_\_\_ Through \_\_\_\_\_

19. Name of referring physician \_\_\_\_\_  
20. For services related to hospitalization give hospitalization dates  
Admitted \_\_\_\_\_ Discharged \_\_\_\_\_

21. Name and address of facility where services rendered (other than office) \_\_\_\_\_  
22. Was laboratory work performed outside your office?  Yes  No Charges \_\_\_\_\_

23. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column by reference to numbers 1, 2, 3, etc. or DX code.  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

24. A. Date of Service	B* Place of Service	C. Fully describe procedures, medical services or supplies furnished for each date given. Procedure Code** (explain unusual services or circumstances)	D. Diagnosis Code**	E. Charges	F.

25. Signature of physician or supplier Signed \_\_\_\_\_ Date \_\_\_\_\_  
26. Accept assignment (Government claims only)  Yes  No  
27. Total Charge \_\_\_\_\_  
28. Amount Paid \_\_\_\_\_  
29. Balance Due \_\_\_\_\_

32. Your Patient's account no. \_\_\_\_\_  
30. Your Social Security Number or Employer's code Number \_\_\_\_\_  
31. Physician's or supplier's name, address, zip code & telephone number \_\_\_\_\_

- \*Place of service codes
- |                              |                                    |  |
|------------------------------|------------------------------------|--|
| 1-(H) - Inpatient Hospital   | 5- - Day Care Facility (PSY)       | 9- - Ambulance                           |
| 2-(OH) - Outpatient Hospital | 6- - Night Care Facility (PSY)     | O- - Other Locations                     |
| 3-(O) - Doctor's Office      | 7-(NH) - Nursing Home              | A-(IL) - Independent Laboratory          |
| 4-(H) - Patient's Home       | 8-(SNF) - Skilled Nursing Facility | H-(IL) - Other Medical/Surgical Facility |

\*\*For surgical procedure code, please use CPT-5 or equivalent for Diagnosis Code ICD-9CM