



PO BOX 890062
CAMP HILL, PA 17089-0062

CLAIM FORM

PATIENT & INSURED (SUBSCRIBER) INFORMATION

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

1. PATIENT'S NAME (First name, middle initial, last name)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)
5. PATIENT'S SEX
6. INSURED'S I.D. (include any letters)
7. PATIENT'S RELATIONSHIP TO INSURED
8. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE-Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
10. WAS CONDITION RELATED TO
11. INSURED'S ADDRESS (Street, city, state, ZIP code)

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?
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE

Table with 8 columns: A DATE OF SERVICE, B PLACE OF SERVICE, C T O S, D FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN, E DIAGNOSIS CODE, F CHARGES, G DAYS OR UNITS, H PERFORMING PROVIDER

25. SIGNATURE OF PHYSICIAN OR SUPPLIER
26. HAS FEE BEEN PAID?
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S OR ACCOUNT'S NAME, ADDRESS, ZIP CODE & PROVIDER NO.
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO.
34. YOUR TELEPHONE NO.