Professional Benefit Administrators, Inc.

Send all bills to:

Professional Benefit Administrators, Inc.
P. O. Box 4687
Oak Brook, IL 60522-4687
(630) 655-3755

MEDICAL CLAIM FORM

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

- Only complete this form when you are submitting a claim for reimbursement, or
- A fully completed claim form is required with the first claim submission of each calendar year. Additional claim submissions do not require the completion of this form unless your claims are the result of a new accident.
- A fully completed claim form is required with dependent claim submissions every six months.
- If you wish to have your benefits paid directly to your physician or hospital, please sign Part D below.
- After completing the front side of this claim form, please see additional instructions on the reverse side.

PART A - Employee Information

Employer Name _____

Employee Name _____ Date of Birth _____ Social Security # _____

Home Address _____ Phone ( )
(street) (city) (state) (zip)

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Spouse's Name _____ Date of Birth _____ Social Security # _____

Is Spouse Employed? Yes ☐ No ☐ If yes, Company Name _____

Address _____ Phone ( )
(street) (city) (state) (zip)

PART B - Dependent Information

Name _____ Relationship _____ Date of Birth _____

Home address if not the same as employee _____
(street) (city) (state) (zip)

Is Dependent employed? Yes ☐ No ☐ Name of Employer _____

Address _____ Phone ( )

If claim is for child over 19 indicate:
A. Student: ☐ Full-Time ☐ High School ☐ Vocational ☐ College
Credit Hours of Study: _____ Name & Address of School _____
B. Handicapped, Please Explain _____

Are you or your dependents entitled to benefits from any other group insurance plan including Blue Cross, Blue Shield, or governmental programs including MEDICARE? ☐ Yes ☐ No
Is other plan an HMO? ☐ Yes ☐ No

A IDENTIFY FAMILY MEMBER INSURED UNDER OTHER PLAN	
B NAME(S) AND ADDRESS OF OTHER INSURANCE COMPANY AND/OR ORGANIZATION	C GROUP POLICY NUMBER

PART C - Claim Information

This claim is for: ☐ Self ☐ Spouse ☐ Unmarried Child Under 19 ☐ Other _____

Claim is for ☐ Sickness/Condition: Briefly explain _____ Date of Symptoms _____
(example: flu, heart attack, pregnancy, etc.)

☐ Accident: Date/Time _____ Where _____

Explain what Happened _____

Did sickness or injury arise out of or in the course of any employment? Yes ☐ No ☐

If yes, explain (include employer's name): _____

CERTIFICATION & AUTHORIZATION TO RELEASE INFORMATION : I certify that these statements and answers are true to the best of my knowledge and belief. I hereby agree to reimburse this plan to the extent that benefits are provided under any Workers' Compensation law, similar legislation, and/or any settlement related to such coverages.

I hereby authorize any insurance company, provider, or any other organization to release all information to PBA, Inc., which may have a bearing on the benefits payable under this plan. A photocopy of this authorization will be considered as effective and valid as the original, and will be valid for one year from the date below.

DATE _____ SIGNATURE OF EMPLOYEE _____ SIGNATURE OF SPOUSE _____
(if claim is on spouse)

PART D - Assignment Authorization

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits, if any, to the provider of services on the reverse side of this form and for those providers whose billings are attached to this form.

Signed (Employee) Date

PLEASE SUBMIT ORIGINAL BILLS AND KEEP COPIES FOR YOUR RECORDS

INSTRUCTIONS FOR SUBMITTING CLAIMS WITH THIS FORM:

Your physician must complete Part E below, unless you have itemized bills which can be attached to this form. (Itemized bills must show the patient's name, date and type of service, amount charged, diagnosis, and provider's Social Security or Federal Tax ID number.)

PART E - Attending Physician Statement

DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE FIRST CONSULTED FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO YEAR? 19

DATE PATIENT ABLE TO RETURN TO WORK	DATE OF TOTAL DISABILITY FROM	THROUGH	DATE OF PARTIAL DISABILITY FROM	THROUGH

NAME OF REFERRING PHYSICIAN	FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED	DISCHARGED

NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)	WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN ICD9 BY REFERENCE TO NUMBER 1,2,3, ETC. OR DX CODE

1.
2.
3.
4.

A DATE OF SERVICE	B * PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES, OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) CPT CODE (IDENTIFY)		D ICD9CM CODE	E CHARGES		F ** T.O.S.	

YOUR PATIENT'S ACCOUNT NO. IF YOU WISH TO IDENTIFY ON CHECK	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE
I DO NOT ACCEPT ASSIGNMENT. ☐			

DOES PATIENT HAVE OTHER HEALTH COVERAGES? YES ☐ NO ☐ IF YES PLEASE IDENTIFY

DATE	PHYSICIAN'S NAME(Please Print)	DEGREE	INDIVIDUAL PRACTITIONER'S SS#
PHYSICIAN'S SIGNATURE		TELEPHONE	ALL OTHER EMPLOYER ID #'S
			Must be furnished under authority of law

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE

*PLACE OF SERVICE CODES:

11 - Office
12 - Home
21 - Inpatient Hospital
22 - Outpatient Hospital
23 - Emergency Room (Hospital)
24 - Ambulatory Surgical Center
25 - Birthing Center
31 - Skilled Nursing Facility
32 - Nursing Facility
33 - Custodial Care Facility
34 - Hospice
41 - Ambulance - Land
42 - Ambulance - Air or Water
51 - Inpatient Psych. Facility
52 - Psych Facility - Partial Hospitalization
53 - Community Mental Health Center
54 - Intermediate Care Facility - Ment. Ret.
55 - Residential Sub. Abuse Treatment Fac.
56 - Psych Residential Treatment Center
61 - Comp. Inpatient Rehab. Facility
62 - Comp. Outpatient Rehab. Facility
65 - End Stage Renal Disease Treatment Fac.
71 - State or Local Public Health Clinic
72 - Rural Health Clinic
81 - Independent Laboratory
99 - Other Unlisted Facility

**TYPE OF SERVICE CODES:

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
M - Alternate Payment for Maintenance Dialysis
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery