

PLEASE SUBMIT ORIGINAL ITEMIZED BILLS WITH A COMPLETED AND SIGNED CLAIM FORM!

IMPORTANT: These forms are electronically scanned, please do not use HIGHLIGHTER or anything else that might distort the information on this form.



EPO
(\$5 co-pay)

SEE REVERSE SIDE FOR
BILLING INFORMATION

**MEDICAL
CLAIM
FORM
690**

TYPE
OR
PRINT

PATIENT INFORMATION (TO BE COMPLETED BY INSURED)

1. INSURED'S Employer		2. INSURED'S Soc. Sec. No.		3. INSURED'S Name, Address and Phone No. <input type="checkbox"/> Check here if this is a new address.	
4. PATIENT'S Name (First name, middle initial, last name)			5. PATIENT'S Date of Birth		
6. PATIENT'S Sex <input type="checkbox"/> M <input type="checkbox"/> F		7. PATIENT'S relation to INSURED <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> other		8. PATIENT'S Status: a. <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other b. Employed full-time Yes <input type="checkbox"/> No <input type="checkbox"/> c. Student full-time Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. Is PATIENT'S condition related to: a. <input type="checkbox"/> Employment? (Current or Previous) b. <input type="checkbox"/> Auto accident? Place _____ (State) c. <input type="checkbox"/> Other accident? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. If Injury: ▶ Describe how and where ▶ ▶ Date _____ ▶ Will you sue? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. INSURED'S Date of Birth		12. INSURED'S Sex <input type="checkbox"/> M <input type="checkbox"/> F		13. Is INSURED now actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO or under <input type="checkbox"/> COBRA	
		14. Date INSURED hired		10. PATIENT'S Address (If different from INSURED'S) and Phone No. <input type="checkbox"/> Check here if this is a new address.	

15. OTHER HEALTH INSURANCE COVERAGE - SECTIONS BELOW MUST BE ANSWERED FOR CLAIM TO BE APPROVED. ◀

A. INSURED'S SPOUSE'S employer (If unmarried or spouse is unemployed check none)
 None Employer Name _____ Phone _____
 Street _____ City _____ State _____ Zip _____

B. Name and address of other insurance company or H.M.O. If none, check None
 None

C. Name of person covered - last & first _____ Date of Birth _____ Sex M F Policy No. or Identification _____

D. Person covered & named in item "C" above is insured's: Self Wife Husband Daughter Son Other (Describe) _____

16. I authorize the release of any medical information necessary to process this request
 Signed (PATIENT or Authorized person) _____ Date _____

17. I authorize payment of benefits directly to the Physician or Supplier named below
 Signed (INSURED or Authorized person) _____

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO INSURED)

DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		IF PATIENT HAS HAD SAME OR SIMILAR SYMPTOMS, GIVE FIRST DATE CONSULTED		HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM _____ TO _____	
DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM _____ TO _____		DATES OF TOTAL DISABILITY FROM _____ TO _____		DATES OF PARTIAL DISABILITY FROM _____ TO _____	
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			OUTSIDE LAB USED? YES <input type="checkbox"/> NO <input type="checkbox"/>		NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Reference 1,2,3 or 4 to PROCEDURE in DIAGNOSIS CODE column)					
1. _____		3. _____			
2. _____		4. _____			

DATE(S) OF SERVICE FROM	TO	Place* of Service	PROCEDURE CODE	EXPLANATION OF SERVICES	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS

FEDERAL TAX I.D. NUMBER		SSN	EIN	PHYSICIAN OR SUPPLIER NAME, ADDRESS AND PHONE NUMBER			TOTAL CHARGES	
ACCEPT ASSIGNMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		PATIENT'S ACCT. No.			AMOUNT PAID			
SIGNATURE				DATE				BALANCE DUE

*PLACE OF (IH) INPATIENT HOSPITAL (OV) DOCTOR'S OFFICE (DCF) DAY CARE FACILITY (IL) INDEPENDENT LAB (OL) OTHER LOCATION

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION WITH THE INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR PERSON IS GUILTY OF A FELONY.

1. COMPLETE THE "**PATIENT INFORMATION**" SECTION (ITEMS 1 THROUGH 14) ON THE REVERSE SIDE OF THIS FORM.

If you wish your medical benefits paid directly to your doctor, sign ITEM 17. A separate form must be submitted for each family member.

2. HAVE YOUR DOCTOR COMPLETE THE "**PHYSICIAN OR SUPPLIER INFORMATION**" SECTION OR SUBMIT COMPLETELY ITEMIZED BILLS.

An itemized bill is one that shows the PATIENT'S name, relationship to INSURED, date of service, type of service rendered, and the nature of the condition being treated.

3. THE COMPLETED FORM AND ITEMIZED BILLS MUST BE SENT TO THE ADDRESS BELOW.

SUBMIT ALL MEDICAL CLAIMS TO:

INSURANCE DESIGN ADMINISTRATORS

P. O. BOX 690

OAKLAND, NJ 07436

ELIGIBILITY AND ALL OTHER INQUIRIES CALL: 1-800-225-1345

IMPORTANT REMINDER

Please be sure you have provided the INSURED'S Social Security Number.

NOTE TO CLAIMANT

Please attach all itemized bills and supporting documents to this completed and signed claim form. Do not use highlighter or anything else that might distort the information on this form; **otherwise, your claim will be delayed.**

NOTE TO ATTENDING PHYSICIAN

If the PATIENT named will be under continuous treatment for the stated condition, there will be no need to fill out an ATTENDING PHYSICIAN'S statement each time a bill is submitted. An itemized bill will be acceptable for processing. However, if the patient consults you for any other condition, a new ATTENDING PHYSICIAN'S statement will be necessary.

INCOMPLETE CLAIM FORMS WILL BE RETURNED FOR COMPLETION. ALSO, IF YOU OR YOUR IMMEDIATE FAMILY ARE COVERED BY ANY OTHER INSURANCE PROGRAMS, INCLUDING MEDICARE, THE "**OTHER HEALTH INSURANCE COVERAGE**" SECTION MUST BE COMPLETED EACH TIME YOU SUBMIT A CLAIM FORM OR YOUR FORM WILL BE RETURNED.