DELTA HEALTH SYSTEMS

REFER TO YOUR I.D. CARD FOR PROPER MAILING ADDRESS

Member Health Care ID Number (HCID)

_____

MEDICAL CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION

1. PATIENT'S NAME	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	6. EMPLOYEE'S ADDRESS (STREET, CITY, STATE, ZIP CODE) ☐ CHECK HERE IF NEW ADDRESS

8. OTHER HEALTH INSURANCE COVERAGE
IS PATIENT COVERED BY ANY OTHER PLAN? ☐ YES ☐ NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER:

IDENTIFICATION NUMBER _____ NAME OF EMPLOYER _____

TYPES OF COVERAGE BY CARRIER: ☐ MEDICAL ☐ DRUG ☐ DENTAL ☐ VISION

EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____

9. I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.	10. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW.
SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____	SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____

PHYSICIAN OR SUPPLIER INFORMATION

11. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	12. DATE FIRST CONSULTED YOU FOR THIS CONDITION	13. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT ☐ YES ☐ NO

14. WAS CONDITION RELATED TO ACCIDENT? ☐ YES ☐ NO IF ACCIDENT RELATED, PLEASE GIVE DETAILS:

15. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE AND ADDRESS	16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED | DISCHARGED
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED	18. WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO CHARGES

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D	PLACE OF SERVICE CODES*		
	1 - INPATIENT HOSPITAL	6 - NIGHT CARE FACILITY(PSY)	B - AMB SURG CTR
	2 - OUTPATIENT HOSPITAL	7 - NURSING CARE	C - RESID TREAT CTR
	3 - DOCTOR'S OFFICE	8 - SKILLED NURSING FAC	D - SPECIALIZED TREAT CTR
	4 - PATIENT'S HOME	9 - AMBULANCE	E - COMP O/P REHAB
	5 - DAY CARE FACILITY(PSY)	O - OTHER LOCATION	F - IND KIDNEY DISEASE TREAT CTR
		A - INDEPENDENT LAB	

20. A DATE OF SERVICE FROM TO	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN CPT-4 PROCEDURE CODE (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS

21. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) DATE:	22. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) ☐ YES ☐ NO	23. TOTAL CHARGES	BALANCE DUE
	24. YOUR TAX IDENTIFICATION NUMBER	25. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER	
26. YOUR PATIENT'S ACCOUNT NUMBER	27. TAXABLE ENTITY NAME (IF DIFFERENT THAN BOX 25)		

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