PLEASE SUBMIT TO P.O. BOX 80, STOCKTON, CA 95201

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, ZIPCODE)

5. PATIENT'S SEX — MALE ☐ FEMALE ☐

6. EMPLOYEE'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

7. PATIENT'S RELATIONSHIP TO EMPLOYEE — SELF | SPOUSE | CHILD | OTHER

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: 0 MEDICAL 0 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.

SIGNED (EMPLOYEE OR PATIENT) ____ DATE ____

10. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICEISI DESCRIBED BELOW.

SIGNED (EMPLOYEE OR PATIENT) ____ DATE ____

PHYSICIAN OR SUPPLIER INFORMATION

11. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY ILMPI

112. DATE FIRST CONSULTED YOU FOR THIS CONDITION

113. 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
- 2 · OUTPATIENT HOSPITAL
- 3 · DOCTOR'S OFFICE
- 4 · PATIENT'S HOME
- 5 · DAYCARE FACILITYIPSYI
- 6 · NIGHT CARE FACILITYIPSYI
- 7 · NURSING CARE
- 8 · SKILLED NURSING FAC
- 9 · AMBULANCE
- 0 · OTHER LOCATION
- A · INDEPENDENT LAB
- B · AMB SURG CTR
- C · RESID TREAT CTR
- D · SPECIALIZED TREAT CTR
- E · COMP O/P REHAB
- F · IND KIDNEY DISEASE TREAT CTR

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

Attach Itemized Bill That Must Include The Below

Name and address of provider	Date of Service
Provider Tax ID	Amount charged for each service
Name of patient	Diagnosis Code
Service provided	Procedure Code

21. SIGNATURE OF PHYSICIAN OR SUPPLIER I INCLUDING DEGREEISI OR CREDENTIALS)

DATE:

22. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLYI — 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 251

FORM NO. 110 REV. 3/13

57055 KiP CORPORATION MEDICAL SYSTEMS