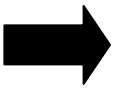
DELTA HEALTH SYSTEMS

MEDICAL CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION

1. MEMBER ID:  Please refer to your medical ID card:		
2. Patient's Name	3. Patient's Date of Birth | |	4. Employee's Name
5. Patient Address (Street, City, State, Zip Code)	6. Patients Sex ☐ Male ☐ Female 8. Patients Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	7. Employee's Address (Street, City, State, Zip Code) ☐ CHECK HERE IF NEW ADDRESS

9. 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 ☐ Vision ☐ Dental

Effective Date of Coverage_____ Termination Date of Coverage_____

10. Was condition related to accident? ☐ Yes ☐ No If yes, please give details:

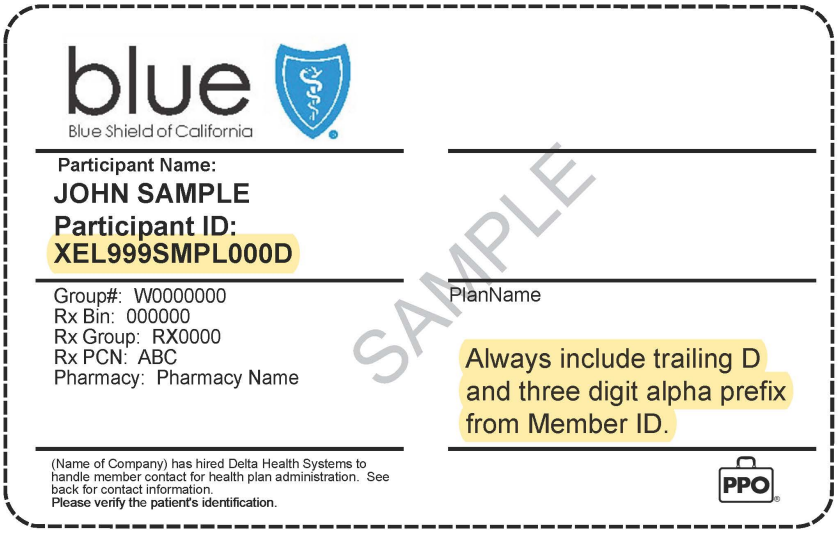
When did the accident occur? (MM/DD/YY) _____

11. Was condition related to Patient's Employment? ☐ Yes ☐ No When did the injury occur? (MM/DD/YY) _____

12. If services are for Massage Therapy, check the following: ☐ 97124 Massage Therapy ☐ 723.9 Diagnosis

13. I authorize the undersigned physician to release any information acquired in the course of my examination or treatment.	14. 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

REFER TO THE BACK OF YOUR I.D. CARD FOR PROPER MAILING ADDRESS



Attach itemized bill. Each itemized bill must include:

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