

MEDICAL CLAIM FORM

Complete this form & attach all bills

MAIL TO



Secure Health Plans of Georgia
 Medical Claims Dept.
 PO Box 13447
 Macon, Georgia 31208-3447

**PART 1 MUST BE COMPLETED BY EMPLOYEE, PLEASE REFER TO INSTRUCTIONS ON REVERSE SIDE**

EMPLOYEE NAME		SOCIAL SECURITY NUMBER		NAME OF EMPLOYER	
HOME ADDRESS		EMPLOYEE DATE OF BIRTH		GROUP NUMBER	
CITY, STATE, & ZIP		HOME PHONE NUMBER		WORK PHONE NUMBER (OPTIONAL)	
PATIENT NAME (___Female ___Male) (IF OTHER THAN EMPLOYEE)	IF OVER AGE 19, IS PATIENT FULL TIME STUDENT? ___YES ___NO	RELATIONSHIP TO EMPLOYEE	PATIENT DATE OF BIRTH	IS PATIENT MARRIED? ___YES ___NO	

IF FULL TIME STUDENT, NAME OF SCHOOL: _____ # OF HOURS ENROLLED? _____

DATE ACCIDENT OR ILLNESS BEGAN	IF INJURED, HOW & WHERE DID ACCIDENT HAPPEN?	DID ACCIDENT OCCUR AT WORK?
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NATURE OF ILLNESS, INJURY, DIAGNOSIS OR MEDICAL CAUSE?	PHYSICIAN'S NAME
	PHYSICIAN'S PHONE NUMBER

NAME OF SPOUSE	SPOUSE DATE OF BIRTH	IS SPOUSE EMPLOYED? IF YES, NAME & ADDRESS OF EMPLOYER.
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ARE YOU, THE PATIENT OR SPOUSE COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION,
 GOVERNMENT PLAN, OR INSURANCE POLICY? YES _____ NO _____
 IF YES, GIVE NAME, ADDRESS, AND POLICY NUMBER OF PLAN PROVIDING BENEFITS.

NAME & ADDRESS, INCLUDING CITY, STATE, & ZIP: _____

SOCIAL SECURITY NUMBER: _____ POLICY NUMBER: _____

ASSIGNMENTS OF BENEFITS**A SIGNATURE IS REQUIRED AS AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER(S)**

I hereby authorize payment of benefits directly to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

Signature of Covered Person_____
Date**AUTHORIZATION TO RELEASE INFORMATION (A patient or parent must sign below)**

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

Signature of Patient or Parent (if minor)_____
Date



PROCEDURES FOR FILING A CLAIM

1. Complete the "Employee, Part 1" section of the form. Make sure you include your SSN and your employer or group name. If the patient is your dependent be sure to complete all questions, including, if married and if a full time student. It is important to know when, how and where your accident, illness or disability began, especially if it is job related. Questions regarding other coverage you or your dependent are eligible for must be answered.
2. If you have other coverage, including Medicare or CHAMPUS, make sure you attach all payment statements or declination letters, this will speed up the payment process.
3. Have your dentist complete "Part2". Attach all dental bills relating to claim, make sure all bills identify patient, and all bills should show date of treatment, type of service, and amount of charges. Make a final check to see that all parts of the claim form are complete.
4. Mail all claims to Secure Health Plans of GA, PO Box 13447, Macon, GA 31208.

PART 2 TO BE COMPLETED BY THE PHYSICIAN

PATIENT'S NAME	PATIENT'S DATE OF BIRTH	DOES PATIENT HAVE OTHER COVERAGE? (If yes, please identify)
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IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES _____ NO _____
GIVE DETAILS

PREGNANCY? YES _____ NO _____	APPROXIMATE DATE PREGNANCY COMMENCED
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DIAGNOSIS AND CONCURRENT CONDITION:

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES _____ NO _____
IF YES, WHEN AND DESCRIBE

REPORT OF SERVICES OR ATTACH ITEMIZED BILL

DATE OF SERVICE	PLACE OF SERVICE	BRIEF DESCRIPTION OF SERVICE RENDERED	PROCEDURE CODE	FEE CHARGED
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE FIRST CONSULTED FOR CONDITION	TOTAL CHARGES	\$
		AMOUNT PAID	\$

IS PATIENT STILL UNDER YOUR CARE FOR CONDITION? YES _____ NO _____	BALANCE DUE	\$
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PHYSICIAN'S NAME _____ GROUP PRACTICE NAME _____
CITY, STATE, ZIP CODE _____ PHONE (_____) _____ FAX _____

PHYSICIAN'S SIGNATURE _____ DATE _____	Direct Payment Cannot Be Made If Not Provided
	TAX ID#: _____
	SSN#: _____