MEDICAL CLAIM FORM
Complete this form & attach all bills

MAIL TO

Secure Health Plans of Georgia
Medical Claims Dept.
PO Box 21347
Eagan, MN 55121

SECUREHEALTH

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

EMPLOYEE NAME	MEMBER 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)	RELATIONSHIP TO EMPLOYEE	PATIENT DATE OF BIRTH	IS PATIENT MARRIED? ____YES ____NO

DATE ACCIDENT OR ILLNESS BEGAN	IF INJURED, HOW & WHERE DID ACCIDENT HAPPEN?	DID ACCIDENT OCCUR AT WORK?

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.

ARE YOU, THE PATIENT OR SPOUSE COVERED UNDER ANY OTHER GROUP PLAN, HEATH MAINTENACE 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 physician complete "Part2". Attach all medical 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 21347, Eagan, MN 55121.

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)

IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES_____NO_____
GIVE DETAILS

PREGNANCY? YES _____ NO _____	APPROXIMATE DATE PREGNANCY COMMENCED

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	$

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#: _____