GROUP RESOURCES®

P.O. Box 100043 · Duluth, GA 30096-9343
(770) 623-8383

GROUP NAME
GROUP NUMBER -

CLAIM FOR HEALTH CARE BENEFITS

1

Employee's Name (Please Print Full Name)	Sex	Marital Status	First Name of Spouse
		□ Single □ Married □ Widowed □ Divorced □ Legally separated	
Employee's Date of Birth			
Home Address		Name and Address of Company where Spouse is Employed	
Employee's Social Security Number		Spouse's Social Security Number	

2

Patient's Name (if other than employee)	Date Covered	Relationship to Employee	If child – is (s)he married? □ Yes □ No	Patient's Birth Date

If child over 19, is (s)he dependent upon your maintenance and support? □ Yes □ No Is (s)he a full time student □ Yes □ No If student, give name and location of school

3

Date accident occurred or sickness began.	Description of injury or sickness	If accident, where and how it occurred.
		Was more than one family member involved in accident? □ Yes □ No If yes, give name(s).
Was illness or injury due, in any way, of the patient's occupation? □ Yes □ No If "yes", explain		Was this an automobile accident? □ Yes □ No

4

Is patient covered by another plan?
Any group insurance, Blue-Cross-Blue Shield or other prepayment arrangement maintained on a group basis? □ Yes □ No
Any other coverage provided by an employer or any federal, state, or other government agency? □ Yes □ No
If "yes" please furnish name and address of employer, insurance company, or governmental agency, type of coverage, and policy number

If eligible, is person enrolled in: Federal Medicare Part A □ Yes □ No Effective Date of Part A is_____
Federal Medicare Part B □ Yes □ No If yes, Effective Date of Part B is_____

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Any person who, knowingly or unknowingly and with or without intent to defraud any insurance company, files a statement of claim containing any material false information or who conceals for the purpose of misleading, information concerning any fact material to the claim, commits a fraudulent insurance act which is a crime (in Florida a felony of the third degree). I hereby certify that the above statements are correct.

Date _____ Signed _____
Employee's Signature

Employer's Name _____

IMPORTANT: THE FOLLOWING AUTHORIZATION MUST BE COMPLETED

To all physicians, hospitals, clinics, dispensaries, druggists, and all other agencies (including other insurance companies): You are authorized to permit Group Resources® or its representative to obtain or view a copy of your records pertaining to the examination, treatment, history, prescriptions, and medical expenses of the patient identified above.

Such information may be used to the extent deemed necessary by Group Resources® to determine the value or amount payable on account of this claim for the patient identified above.

_____ _____
Patient's Signature/Parent if Patient is Minor **Date**

PHYSICIAN'S STATEMENT

PATIENT INFORMATION

1. Patient's Name (First name, middle initial, last name)

2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical information necessary to process this claim.

SIGNED

3. I authorize payment of Medical Benefits to undersigned Physician or Supplier for services described below. This authorization is invalid unless Tax I.D. of provider is given below.

Signed (covered or authorized person)

PHYSICIAN OR SUPPLIER INFORMATION

4. Date of Illness (first symptoms) OR injury (accident) OR pregnancy (LMP)

5. Date first consulted you for this condition

6. Has patient ever had same or similar symptoms?
□ Yes □ No

7. Date patient able to return to work

8. Dates of total disability
From Through

9. Dates of partial disability
From Through

10. Name of referring physician

11. For services related to hospitalization give hospitalization dates
Admitted Discharged

12. Name & address of facility where services rendered (if other than home or office)

13. Was laboratory work performed outside your office?
□ Yes □ No Charges:

14. Diagnosis or nature of illness or injury. (Relate items 1, 2, 3, or 4 to item 15E by line).
1.
2.
3.
4.

15. A Date of Service	B Place of Service	C Type of Service	D Procedures, services, or supplies (Explain unusual circumstances) CPT/HCPCS	D MODIFIER	E DIAGNOSIS CODE	F CHARGES	G DAYS OR UNITS	H ADDITIONAL INFORMATION
						$		
						$		
						$		
						$		
						$		
						$		
						$		
						$		
						$		

16. Signature of Physician or Supplier

Signed Date

17. Accept Assignment
□ Yes □ No

18. Total Charge

19. Amount Paid
$

20. Balance Due
$

21. Physician Social Security No.

22. Physician's or Supplier's name, address, zip code & telephone number

23. Your patient's Account No.

24. Physician's Tax I.D. No.

I.D. No.