

Great-WestSM HEALTHCARE

MEDICAL CLAIM FORM

PART A - MEMBER STATEMENT - Failure to Answer All Questions May Delay Payment											
1. Member's Name			Street Address			City or Town			ZIP Code		
2. Plan Number		Social Security #			Are you still employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			If no, enter date last worked			
3. Date of Birth		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed			Name of Your Employer			Occupation			
4. Spouse's Date of Birth		Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, enter the name and address of spouse's employer						
5. Are you or your dependents covered under another group insurance or government plan such as Medicare, an HMO or automobile no fault coverage, which will also cover any of the medical expenses on the claim? <input type="checkbox"/> Yes <input type="checkbox"/> No					If yes, enter name and address: Policy # / ID #: Family Member Holding Policy:						
6. Is claim for a dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, enter dependent name (first, last)			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	Relationship to Member	If dependent is a child, are you entitled to a tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6a. If child, is he/she married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is child over 19? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, is child a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, enter name of school					
7. Is claim for an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date: Time:	Where did it occur?			While working? <input type="checkbox"/> Yes <input type="checkbox"/> No		How did it occur?			
8. SIGN HERE IF YOU WANT BENEFITS PAID TO DOCTOR/HOSPITAL								DATE:			
9. SIGN HERE FOR ALL CLAIMS								DATE:			
I hereby authorize any insurance company, hospital, or physician to release all information which may have a bearing on benefits payable under this plan of benefits.											
PART B - DOCTOR OR SUPPLIER - Complete and Return to Patient											
Patient's Name			Date of Birth		Date first consulted for condition		Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Referring Physician		
Date patient able to return to work			Dates of total disability From _____ Through _____			Dates of partial disability From _____ Through _____					
Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column D by reference to numbers 1, 2, 3, etc. or DX Code									Is condition related to work incurred injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
1.			3.			2.			4.		
A Date of Service	B Place of Service	C Describe fully procedures, medical services, or supplies furnished for each date given Procedure Code (Identify:) (Explain unusual Services or Circumstances)				D DX Code (ID:)	E Charges				
Signature of Physician								Total Charges	Amount Paid	Balance Due	
Signed _____ Date: _____											
Provider's Social Security # / Tax ID #			Physician's Name, Address, ZIP Code					Telephone (Include Area Code)			

Place of Service Codes

- | | | | |
|-------------------------------|--------------------------------|-------------------------------------|-------------------------------------|
| 1. (IH) - Inpatient Hospital | 4. (H) - Patient's Home | 7. (NH) - Nursing Home | 10. (OL) - |
| 2. (OH) - Outpatient Hospital | 5. - Day Care Facility | 8. (SNF) - Skilled Nursing Facility | 11. (IL) - Independent Laboratory |
| 3. (O) - Doctor's Office | 6. - Night Care Facility (PSY) | 9. - Ambulance | 12. Other Medical/Surgical Facility |

Group Medical Claim - HOW TO FILE A CLAIM

Member

1. Complete Part A - One for each family member
2. If claim is for a dependent, also complete lines 6 & 6a
3. If claim is for an accident, complete line 7
4. For all claims, sign line 9
5. If you want benefits paid to doctor/hospital, sign form on line 8
6. Enclose a copy of other carriers' payment worksheet when you have other insurance.
7. Ask your doctor to provide itemized bills with diagnosis for care

Doctor/Dispenser

1. Complete Part B
2. Or, attach Itemized Bill which includes Diagnosis for care
3. Sign form - return to patient

Forward Completed Claim Forms to:
1000 Great-West Drive
Kennett, MO 63857-3749

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against a claims administrator of payer, submits an application or files a claim containing a false or deceptive statement is guilty of fraud. Such action is considered to be a felony in some states.

Authorization is valid for the duration of the claim. Claimant or Claimant's authorized representative is entitled to receive a copy of this form.

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