



HEALTH CLAIM FORM

PATIENT INFORMATION

1. EMPLOYEE'S SSN		GROUP NUMBER		GROUP NAME	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTHDATE (mm/dd/yr) M <input type="checkbox"/> F <input type="checkbox"/>		4. EMPLOYEE'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No. Street)		6. PATIENT RELATIONSHIP TO EMPLOYEE Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. EMPLOYEE'S ADDRESS (No. Street)	
CITY	STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ()	Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student <input type="checkbox"/>		ZIP CODE	TELEPHONE (Include Area Code) ()
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO		11. EMPLOYEE'S POLICY GROUP	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO []		a. EMPLOYEE'S DATE OF BIRTH (mm/dd/yr) SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH (mm/dd/yr) SEX M <input type="checkbox"/> F <input type="checkbox"/>		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. CLAIMS ADMINISTRATOR	
c. EMPLOYER'S NAME OR SCHOOL NAME		d. PLEASE PROVIDE ACCIDENT DETAILS: _____ _____		MCA Administrators, INC. Manor Oak Two, Suite 605, 1910 Cochran Road Pittsburgh, PA 15220 (800) 922-4966	
d. OTHER INSURANCE PLAN NAME OR PROGRAM NAME				c. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO # yes, return to and complete item 9 a-d	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	

PHYSICIAN/SUPPLIER INFORMATION OR ATTACH ITEMIZED BILLING THAT CONTAINS THE INFORMATION REQUESTED BELOW

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) (mm/dd/yr)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (mm/dd/yr)		16. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO						
17. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____				18. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.						
19. PRIOR AUTHORIZATION NUMBER										
20. A	B	C	D	E	F	G	H	I	J	
DATE(S) OF SERVICE From (mm/dd/yr) To (mm/dd/yr)	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstance) CPT HCPCS MODIFIER	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSOT Family Plan	EMG	COB	
1										
2										
3										
4										
5										
6										
21. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		22. PATIENT'S ACCOUNT NO.		23. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		24. TOTAL CHARGE		25. AMOUNT PAID		26. BALANCE DUE

27. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____ DATE _____		28. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		29. PHYSICIAN/SUPPLIER BILLING ADDRESS: PIN# _____ GRP# _____	
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