90 DEGREE BENEFITS
A Turn For The Better

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 SEX (mm/dd/yr) | | M ❒ F ❒	4. EMPLOYEE'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No. Street)	6. PATIENT RELATIONSHIP TO EMPLOYEE Self ❒ Spouse ❒ Child ❒ Other ❒	7. EMPLOYEE'S ADDRESS (No. Street)
CITY / STATE	8. PATIENT STATUS Single ❒ Married ❒ Other ❒ Employed ❒ Full-time Student ❒ Part-time Student ❒	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		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) ❒ YES ❒ NO	11. EMPLOYEE'S POLICY GROUP
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? PLACE (State) ❒ YES ❒ NO [_____]	a. EMPLOYEE'S DATE OF BIRTH SEX (mm/dd/yr) | | M ❒ F ❒
b. OTHER INSURED'S DATE OF BIRTH SEX (mm/dd/yr) | M ❒ F ❒	c. OTHER ACCIDENT? ❒ YES ❒ NO	b. CLAIMS ADMINISTRATOR **90 Degree Benefits, INC.** Manor Oak Two, Suite 605, 1910 Cochran Road Pittsburgh, PA 15220 (800) 922-4966
c. EMPLOYER'S NAME OR SCHOOL NAME	d. PLEASE PROVIDE ACCIDENT DETALS: _____ _____	
d. OTHER INSURANCE PLAN NAME OR PROGRAM NAME		c. IS THERE ANOTHER HEALTH BENEFIT PLAN? ❒ YES ❒ NO ***If 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 ❒ YES ❒ 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 DATE(S) OF SERVICE From (mm/dd/yr)	To(mm/dd/yr)	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstance) CPT HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSOT Family Plan	I EMG	J COB
1											
2											
3											
4											
5											
6											

21. FEDERAL TAX I.D. NUMBER SSN EIN ❒ ❒	22. PATIENT'S ACCOUNT NO.	23. ACCEPT ASSIGNMENT? ❒ YES ❒ 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#