HealthComp®
Third Party Administrators

GROUP MEDICAL CLAIM FORM

SUBMIT CLAIMS TO: P.O. BOX 45018, FRESNO, CA 93718-5018 Phone: (800) 442-7247. Fax: (559) 499-2464. Email: Scanform@HealthComp.com

1. Your Policy and/or Group number(s)

2. Name and address of employer

EMPLOYEE INFORMATION

3. Name of employee *(insured)* | ☐ Male ☐ Female | Date of Birth

4. Address of employee Street City State Zip Code

5. Employee's Medical ID or Social Security number

6. Name of Spouse or Domestic Partner | Date of Birth | Social Security number

7. (a) Are you or any member of your family covered under Medicare? ☐ Yes ☐ No
(b) Are you or any member of your family covered under another Group Plan providing medical benefits? ☐ Yes ☐ No

REMARKS: If you have checked Yes to any of the above, please provide policy number _____
Effective date _____
Name of insured _____
Name and address of insurance company _____
Name and address of the employer or organization which sponsors the coverage _____

If you are covered by Medicare, or any other basic hospitalization or surgical plan such as Blue Cross-Blue Shield, please submit these carrier's payment statements or declinations along with itemized bills.

COMPLETE FOR INJURY OR ILLNESS

8. This claim is for ☐ Employee ☐ Spouse or Domestic Partner ☐ Child

9. This claim is for ☐ ILLNESS

GIVE TIME AND DATE. BRIEFLY DESCRIBE HOW INJURY OCCURRED.

☐ ACCIDENT ON

Does this claim involve a work-related illness or injury? ☐ Yes ☐ No

IF CLAIM FOR DEPENDENT, COMPLETE THIS SECTION ALSO

10. Name of your dependent | ☐ Male ☐ Female | Date of Birth | Social Security number if dependent

11. Is dependent employed? ☐ Yes ☐ No Name of dependent's employer

12. Address of employer Street City State Zip Code

IMPORTANT – PLEASE COMPLETE AUTHORIZATION SECTION

13. AUTHORIZATION TO RELEASE INFORMATION:

The above answers are true and correct to the best of my knowledge. I hereby authorized any physician, surgeon, practitioner or other person, any hospital, including veterans administration or government hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A Photostat of this authorization shall be as valid as the original.

Signed (Patient or Parent if Minor) **Date**

14. ASSIGNMENT OF, AND AUTHORIZATION TO PAY, BENEFITS:

I hereby assign my rights to benefits (including all rights arising under § 514(a) of ERISA, 29 U.S.C. §1144(a)) to, and authorize payment directly to, the Physician named above for those benefits to which the Plan Member is entitled, provided the benefits paid do not exceed the Physician's regular charges. I understand I am financially responsible to the Physician for charges not covered by this assignment.

Signed (Patient or Parent if Minor) **Date**

Please attach itemized bills to this form and mail to : HEALTHCOMP, INC.

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Dental Claim Form

Check one:

☐ Dentist's pre-treatment estimate
☐ Dentist's statement of actual services

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PATIENT COVERAGE

1. Patient Name First MI Last	2. Relationship to employee ☐ self ☐ spouse ☐ domestic partner ☐ child ☐ other_____	3. Sex ☐ male ☐ female	4. Patient birth date MM DD YYYY	5. If full-time student School City

6. Employee /subscriber name and mailing address	7. Employee Soc. sec. or I.D. number	8. Employee birthdate MM DD YYYY	9. Employer name and address	10. Group number

11. Is patient covered by another dental plan? ☐ yes ☐ no If yes complete 12-a thru 15. Is patient covered by a medical plan? ☐ yes ☐ no	12-a Name and address of carrier(s)	12-b Group no(s)	13. Name and address of other employer(s)

14.-a Employee name (if different than patient's)	14-b Employee Soc. sec. or I.D. number	14-c Employee birthdate MM DD YYYY	15. Relationship to patient ☐ self ☐ parent ☐ domestic partner ☐ spouse ☐ other_____

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

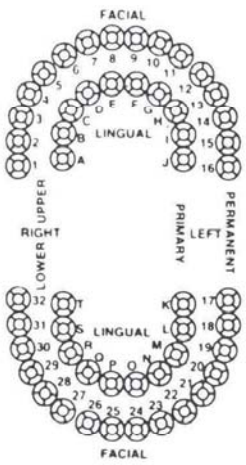
Signed (Patient or parent if minor) _____ Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signed (Insured person) _____ Date _____

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity	24. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
17. Address where payment should be remitted	25. Is treatment result of auto accident?			
City State Zip	26. Other accident?			
18. 19. 20.	27. If prosthesis, is this initial placement?			(If no, reason for replacement) 28. Date of prior placement
21. First visit date current series / 22. Place of treatment: Office Hosp ECF Other / 23. Radiographs or models enclosed? No Yes How many?	29. Is treatment for orthodontics?			If services already Commenced enter / Date appliances placed / Mos. treatment remaining



30. Examination and treatment plan – List in order from tooth no 1 through tooth no 32 – Use charting system shown

Tooth # or letter	Surface	Description of service (Including x-rays, prophylaxis, materials used, etc.)	Date of Service Performed Mo Day Year	Procedure Number	Fee	For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Treating Dentist) _____ License Number _____ Date _____

Total Fee Charged	
Max Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

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