TRIBAL
HEALTH PARTNERS T.P.A., L.L.C.

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Insurance Claim Form (Medical)

Instructions

1. Complete the front side of this form in full.
2. When the form is complete, send it along with the itemized hospital and medical bills to our office.
3. Do not complete a claim form with each bill you send.

Social Security Number_____ Policy Number_____

1. Name of Policyowner_____Date of Birth_____Occupation_____

Address:_____Zip Code_____Phone:_____

Name and address of Employer_____

2. Patient's name, if other than policyowner_____Date of Birth_____Occupation_____Marital Status_____

Name and address of employer_____

3. Is patient covered by any other insurance? π Yes π No
If yes, give company name, address and policy number _____

4. If claim is due to an accident, how did it occur? Date of Accident_____

_____

5. If claim is due to sickness, please describe_____

Date of first symptoms_____ Date first treated_____

6. Name and Address of attending physician and hospital, if hospitalized_____

_____

7. Has patient ever had a similar condition? π Yes π No
If yes, when and describe _____

_____

_____

8. If claim is for pregnancy, Date of delivery_____ Name of Child _____

9. Did accident or sickness arise in the course of employment? π Yes π No

10. If person treated was disabled, please indicate: _____

a) the first date patient could do no work because of sickness or injury Date:_____20_____
b) the first date patient could resume some of his/her important duties Date:_____20_____
c) the first date patient could resume all of his/her important duties Date:_____20_____

I certify that the foregoing statements and answers are true and complete to the best of my knowledge and belief.
The furnishing of this blank is for the convenience of the policyowner and is not an acknowledgement of liability or waiver of any kind.

Authorization To Obtain Information

I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or employer, having information available as diagnosis, treatment and prognosis with respect to any physical or mental condition, treatment of me or my minor children to give A.B.S./Tribal Health Partners or its legal representative, any and all such information.

I understand the information obtained by use of the authorization will be used by A.B.S./Tribal Health Partners, for claim purposes.

Any information obtained will not be released by A.B.S./Tribal Health Partners, to any person or organization EXCEPT to reinsuring companies or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize.

I agree that a photocopy of this authorization will be as valid as the original.

I agree that this authorization will be valid for two years form the date shown below.

Patient's Signature:_____Date:_____

Policyowner's Signature:_____Date:_____

Continued on reverse side

To Be Completed By Patient (insured)

Patient's Name and Address_____Date of Birth_____
Insured's Name if patient is a dependent_____

Authorization to pay benefits to Physician: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or medical benefits, if any, otherwise payable to me for his services as described below but not to exceed the reasonable and customary charge for those services.

Signed (Insured Person)_____Date:_____

Attending Physician Statement

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA* used, give name):_____

2. Is condition due to injury or sickness arising out of patient's employment? π Yes π No
Pregnancy? π Yes π No If yes, approximate date pregnancy commenced. Date: _____

3. Report of services or attach itemized bill. (If previous form submitted to this carrier, you need to show only dates and services since last report.)

Date of Services	Place of Services	Description of surgical or Medical services rendered	Procedure Code* If used (if code other than CPT** Give name)	Charges
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

O Doctor's Office **OH** Outpatient Hospital ****CPT** Current Total Charges $_____
IH Inpatient Hospital **OL** Other locations Procedural Terminolgy
NH Nursing Home ***ICDA**-International (current edition) Amount Paid $_____
H Patient's Home Classification of Diseases
Balance Due $_____

4. Date symptons first appeared or accident happened. _____

5. Date patient first consulted you for this condition. _____

6. Patient ever had same or similar condition? π Yes π No

7. Patient still under your care for this condition? π Yes π No

8. Patient was continually totally disabled (Unable to work). From _____to_____

9. Patient was partially disabled. From_____to_____

10. If still disabled, date patient should be able to return to work. From_____to_____

11. Patient was house confined. From_____to_____

12. Does Patient have other health coverage? π Yes π No
If yes, please identify_____

13. I do not accept assignment.

14. Social Security Number or Taxpayers Identification No. (Required to be furnished under authority of law)_____

Name of Clinic (Print)_____

Date_____Physicians Name (Print)_____Signature_____

Degree_____Telephone (_____)_____

Street Address _____

City/Town_____State_____Zip Code_____