CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS
3. MAIL TO →

FOR PROMPT PAYMENT
COMPLETE REVERSE SIDE

First Benefit Administrators

Pursuant to Section 817.234. FLORIDA Statutes…Any person who knowingly and with intent to injury defraud, or deceive any employer or employee, Insurance Company or self-insured program, files a statement of claim containing false or misleading information is guilty of a felony of the third degree.

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www.firstbenefitadmin.com

GROUP NO.

PART 1 MUST BE COMPLETED BY EMPLOYEE
(Please Print)

Employee Name	Date of Birth	Employer Name	FBA or Medical ID Number

Address: Number and Street	City	State	Zip Code	Phone: Work / Home

Dependent Name (If Patient)	Relationship to Employee ☐ Spouse ☐ Child ☐ Other _____	If over 19 & full time student / Name of School	Date of Birth

Date Injury or Sickness Began	Is Claim Being Made For Workman's Comp? Yes No	Physician Name

Nature of Sickness, Injury, Diagnosis or Medical Call

If injured, How, When and Where Did Accident happen?

☐

Are you married? Yes / No — Spouse Name	Name and Address of Spouse Employer (If not Employed Write "Not Employed")

☐ ☐

Are you or your dependent covered under any other Group Insurance, Health Maintenance Organization, Federal Plan or Union Welfare Plan which may also pay for any of the expenses of this claim?
Yes No If Yes, complete all information below:

Name and Address of Ins. Co.	Policy / Contract #	Name of Policyholder	Parties Covered under Plan	Effective Date

IF PAYMENT IS TO BE MADE TO PHYSICIAN SIGN BELOW	PATIENT OR PARENT MUST SIGN BELOW
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN. I hereby authorize payment directly to the undersigned Physician, otherwise payable to me for his services, but not to exceed the reasonable and customary charge for those services or the contracted network fees.	AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize any Physician to release any information acquired in the course of my examination or treatment.
SIGNED (Patient or Parent) Sign Only If Payment is to Go to Doctor. X Date	SIGNED (Patient or Parent if Minor) X Date

PART 2 MUST BE COMPLETED BY PHYSICIAN
(Please Print)

Patient Name	Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Sex ☐ Male ☐ Female	Patient Date of Birth Mo Day Year	Full-Time Student ☐ Yes ☐ No Name of School

Employee Name First Middle Last	FBA or Medical Plan #
Employee Mailing Address	Employer (Company) Name and Address

City	State	Zip Code	

Are Other Family Members Employed? ☐ Yes ☐ No Employee Name Soc. Sec. No.	Name and Address of their Employer

Is Patient Covered by Another Health Plan? ☐ Yes ☐ No	Group No.	Name and Address of Carrier

Diagnosis and Concurrent Conditions
(If Diagnosis Code Other Than ICD9* Use Diagnosis Name)

Is Condition Due to Injury or Sickness Arising Out of Patient's Employment? ☐ Yes ☐ No	Pregnancy? ☐ Yes ☐ No	If Yes, Approximate Date Pregnancy Commenced: Date

Report of Services (or Attached Itemized Bill)

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code If Used (IF CODE OTHER THAN CPT Used Give Name)	Charges	Claims Office Use Only

	TOTAL CHARGES	$
	AMOUNT PAID	$
Was Patient Referred? ☐ Yes ☐ No If so, by whom?	BALANCE DUE	$

Date Symptoms First Appeared or Accident Happened	Date Patient First Consulted You for This Condition	Is Patient Still Under Your Care for This Condition? ☐ Yes ☐ No

Has Patient Ever Had Same or Similar Condition? ☐ Yes ☐ No If "Yes" When and Describe	Patient Was Continuously Totally Disabled (Unable To Work) From: Thru:

Date Last Worked	Date Employee Returned to Work:	If Still Disabled, Date Patient Should Be Able To Return To Work

Physician Name (Print)	License # / Degree

Mailing Address	City	State	Zip Code

Telephone	Fax	E-mail

Signature X	Date	SS# or TIN#

INSTRUCTIONS FOR FILING

1. Complete the employee's portion – Part 1
2. Have your Physician complete the Attending Physician Statement – Part 2
3. Have your Physician return the form to you or forward to Florida Benefit Administrators