

**SELF INSURED PLANS LLC**

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**Statement of Claim**  
 To Be Completed By The Employee

Employer Name \_\_\_\_\_

Group No. \_\_\_\_\_

**Submit only itemized bills. Drug receipts should always include a prescription number. If you submit bills for covered services not reported on an "Attending Physician's Statement," each bill must describe name of patient, diagnosis, nature of services or supplies furnished, as well as the date and amount charged for each.**

Full Name		Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Retired		Social Security Number	
Home Address		Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated		First name of spouse	Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No
City	State	ZIP Code	Name and address of company where spouse is employed		
Date of Birth	Telephone Number		Spouses's Social Security Number		
Patient's Name	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Marital status if other than spouse: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated	
Is patient eligible for Medicare as a disabled person or due to renal dialysis or kidney transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, effective date of Medicare is:					
If patient is a child 19 or over: name and address of school				Date of enrollment	<input type="checkbox"/> Full time <input type="checkbox"/> Part time
If bills are being submitted for nursing services or physiotherapy, enclose a statement from your physician showing that he ordered all such services. <input type="checkbox"/> Yes					
Also, were any such services rendered by a close relative, that is, your spouse or child, brother, sister or parent of either yourself or your spouse? <input type="checkbox"/> No					
Date accident occurred or sickness began?	Description of injury or sickness. If accident, date, how and where it occurred.				
Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No - If "Yes," explain					
<b>IS PATIENT COVERED BY ANOTHER PLAN</b>					
1. Any other Group Plan, Welfare Plan or other arrangement of coverage for individuals in a group?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Blue Cross, Blue Shield or any other prepayment arrangement maintained on a group basis?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Any other coverage provided by an employer or any federal, state, or other governmental agency?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. No-fault automobile plan as a result of injuries sustained in an automobile accident?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes" please furnish name and address of employer, insurance company or governmental agency, type of coverage, and policy number.					
THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE ANY EMPLOYER, INSURANCE COMPANY, MEDICAL PREPAYMENT PLAN, SERVICE ORGANIZATION, PHYSICIAN, PRACTITIONER OR OTHER PERSON; ANY HOSPITAL, INCLUDING THE VETERANS ADMINISTRATION, OR OTHER INSTITUTION TO RELEASE OR OBTAIN FROM SIP, ANY MEDICAL OR BENEFIT PAYMENT INFORMATION THAT MAY BE REQUIRED TO ESTABLISH THE VALIDITY OF THIS CLAIM, AND FURTHER AUTHORIZE SAID COMPANY, PERSON OR ORGANIZATION, TO DISCLOSE ANY PERSONAL OR CLAIM INFORMATION REQUIRED FOR MEDICAL CASE STUDY OR REVIEW. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.					
Spouse's Signature and date			Employee's Signature and date		
<b>Assignment of Benefits</b>					
I hereby authorize payment directly to the physician, hospital, or supplier who provided services for which benefits are payable, but not exceed the usual and prevailing charge.					
Employee's Signature					Date

# Hospital/Attending Physician's Statement

To Be Completed By Physician/Supplier (THIS SECTION DOES NOT HAVE TO BE COMPLETED IF YOU PROVIDE ITEMIZED BILLS)

Employee's Last Name	First Name	Patient's Name (if patient is dependent)	Date of birth
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, approximate date pregnancy commenced
3. Report of Services (or inclose itemized bill) (if previous form submitted to SIP, you need to show only the 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** used, give name) Charges
† O - Doctor's Office H - Patient's Home IH - Inpatient Hospital		OH - Outpatient Hospital NH - Nursing Home OL - Other Locations	* ICDA - International Classification of Diseases ** CPT - Current Procedural Terminology (current edition)
		Total Charges \$ _____	Amount Paid \$ _____
		Balance Due \$ _____	
4. Date symptoms first appeared or accident happened		5. Date patient first consulted you for this condition	
6. Patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and describe:		7. Patient still under your care for this condition <input type="checkbox"/> Yes <input type="checkbox"/> No	
		8. I accept Medicare's assignment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Physicians's Name		Individual health care practitioners enter your social security number *	All others enter your employer identification number *
Signature	Degree	Telephone No.	Date
Street Address	City or Town	State	ZIP Code

\* Under Section 6109 of the Internal Revenue Code, recipients of medical and health care payments are required to furnish identifying numbers to payers who must report such payments to the Internal Revenue Service.

**"NOTICE to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts."**