GROUP EXCESS MEDICAL

STATEMENT OF CLAIM
FROM ALL OTHER CARRIERS
FOR CO-INSURANCE BENEFITS

TO FILE: ATTACH COPIES OF
PAYMENT STATEMENTS
FROM ALL OTHER CARRIERS

1225 Franklin Avenue, Suite 475
Garden City, NY 11530

EMPLOYER'S CERTIFICATION

Employer's Name	Employer's Address (Street, City, State, Zip Code)	Policy Number **XGMM-**
Employee's Name(Last, First, Middle Initial)	Date Employed	Occupation
Employee's Social Security No.	Date Employee Insured	Date Dependents Insured
Employee's Status ☐ Active ☐ Retired	Type of Excess Coverage ☐ Individual ☐ Family	If Coverage is terminated, give date
Signature & Title of Authorized Person		Date

EMPLOYEE'S STATEMENT *(Complete for all claims)*

Employee's Name (Last, First, Middle Initial)		Employee's Address (Street, City, State, Zip Code)
Employee Date of Birth	Employee's Social Security No.	Telephone No.
Claims for ☐ Self ☐ Spouse ☐ Child	Patient's Name (Last, First, Middle)	Employee's Status ☐ Male ☐ Single ☐ Divorced ☐ Widow ☐ Female ☐ Married ☐ Seperated ☐ Widower
Patient's Date of Birth	Is Patient on Medicare? ☐ Yes ☐ No	

COMPLETE IF EMPLOYEE IS MARRIED

Name of Spouse	Spouse Social Security No.	Is Spouse Employed? ☐ Yes ☐ No
If you answered " Yes" to the previous question, give name, address and phone number of spouse's employer		
Name(s) and Address(es) of spouse's health insurance carrier(s)		Policy Number(s)
Spouse's Insurance I.D. Number	Spouse's Coverage ☐ Individual ☐ Family	Are there any other health insurance benefits available from any other source? ☐ Yes ☐ No If "Yes" please give details in space below.

COMPLETE IF CLAIM IS FOR YOUR DEPENDENT CHILD

Child's Name	Indicate if child is ☐ Student ☐ Married ☐ Handicapped	Child lives at ☐ Home ☐ School
If Child is in school and between ages 18 and 25, give school name and address		
Is child employed? ☐ Yes ☐ No If "Yes" give name and address of employer.		
Employer's Phone No.	Name of child's health insurance carrier and policy number	

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containg any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

COMPLETE FOR ALL CLAIMS

I hereby authorize any Insurance Company, Prepayment Organization, Employer or provider of medical services to releases all information with respect of myself or my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information given by me in support of this claim is true and correct. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Dependent Signature (If patient and not minor)	**Date**	**and Employee Signature**

Health Insurance
Claim Form
TO BE COMPLETED BY THE ATTENDING PHYSICIAN ***(If benefits to be assigned)***

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, Zip Code)*	5. PATIENT'S SEX MALE FEMALE	6. INSURED'S I.D. No. *(Soc. Sec . No)*
	7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	8. INSURED'S GROUP NO. *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Name and Address and Policy or Medical Assistance Number	10. W AS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES NO B. AN AUTO ACCIDENT YES NO	11. INSURED'S ADDRESS *(Street, city, State, Zip code)*
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *I authorize the Release of any Medical Information Necessary to process this claim.*		13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.*
SIGNED *DATE*		*SIGNED (Insured or Authorized Person)*

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF;	ILLNESS (FIRST SYMPTOM) OR INJURY(ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
17. DATE PATIENT ABLE TO RETURN TO W ORK	18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN			20. FOR SERVICES RELATED TO HOSPITALIZATION ADMITTED DISCHARGED
21. NAME 7 ADDRESS OF FACILITY W HERE SERVICES RENDERED *(if other than home or office)*			22. W AS LABORATORY W ORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES:

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.
4.

24. A	B *	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D	E	F
DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	DIAGNOSIS CODE	CHARGES	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER		26. TOTAL CHARGES	27. AMOUNT PAID 28. BALANCE DUE

SIGNED DATE 29. YOUR SOCIAL SECURITY NO. 30. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.