



# GROUP EXCESS MEDICAL

## STATEMENT OF CLAIM FOR CO-INSURANCE BENEFITS



**EMPLOYER'S CERTIFICATION**

TO FILE: ATTACH COPIES OF PAYMENT STATEMENTS FROM ALL OTHER CARRIERS.  
MAIL TO: Fitzharris & Co., Inc., P.O. Box 9182, Farmingdale, NY 11735-9182 • TEL: (516) 777-2244

Employer's Name		Employer's Address (Street, City, State, Zip Code)		Policy Number <b>XGMM-</b>
Employee's Name (Last, First, Middle Initial)		Date Employed		Occupation
Employee's Social Security No.		Date Employee Insured	Date Dependents Insured	
Employee's Status <input type="checkbox"/> Active <input type="checkbox"/> Retired		Type of Excess Coverage <input type="checkbox"/> Individual <input type="checkbox"/> 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's Date of Birth	Employee's Social Security No.	Telephone No.	
Claims for <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Patient's Name (Last, First, Middle)	Employee's Status <input type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widower	
Patient's Date of Birth	Is Patient on Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**COMPLETE IF EMPLOYEE IS MARRIED**

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

**COMPLETE IF CLAIM IS FOR YOUR DEPENDENT CHILD**

Child's Name	Indicate if child is <input type="checkbox"/> Student <input type="checkbox"/> Married <input type="checkbox"/> Handicapped	Child lives at <input type="checkbox"/> Home <input type="checkbox"/> School
If child is in school and between ages 18 and 25, give school name and address		
Is child employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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 containing 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 to myself or my dependants, 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
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**Health Insurance  
Claim Form**

**TO BE COMPLETED BY THE ATTENDING PHYSICIAN (If benefits to be assigned)**

<b>PATIENT &amp; INSURED (SUBSCRIBER) INFORMATION</b>					
1. PATIENT'S 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 <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. INSURED'S I.D. No. (Soc. Sec. No.)	
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number		7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		8. INSURED'S GROUP NO. (Or Group Name)	
		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S ADDRESS (Street, city, state, ZIP code)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <i>I authorize the Release of any Medical Information Necessary to Process this Claim.</i>				13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.	
SIGNED _____		DATE _____		SIGNED (Insured or Authorized Person) _____	
<b>PHYSICIAN OR SUPPLIER INFORMATION</b>					
14. DATE OF: <input type="text"/>		ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM <input type="text"/> THROUGH <input type="text"/>		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19. NAME OF REFERRING PHYSICIAN			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED <input type="text"/> DISCHARGED <input type="text"/>		
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)				22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> 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 DATE OF SERVICE	B * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D DIAGNOSIS CODE	E CHARGES
		PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)		
25. SIGNATURE OF PHYSICIAN OR SUPPLIER			27. TOTAL CHARGES		
SIGNED _____			28. AMOUNT PAID		
DATE _____			29. BALANCE DUE		
32. YOUR PATIENT'S ACCOUNT NO.			30. YOUR SOCIAL SECURITY NO.		
			31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
			33. YOUR EMPLOYER I.D. NO.		
			I.D. NO.		

\* PLACE OF SERVICE CODES

1 - (IH) - INPATIENT HOSPITAL	4 - (H) - PATIENT'S HOME	7 - (NH) - NURSING HOME	O - (OL) - OTHER LOCATIONS
2 - (OH) - OUTPATIENT HOSPITAL	5 - DAY CARE FACILITY (PHY)	8 - (SNF) - SKILLED NURSING FACILITY	A - (IL) - INDEPENDENT LABORATORY
3 - (O) - DOCTOR'S OFFICE	6 - NIGHT CARE FACILITY (PHY)	9 - AMBULANCE	B - OTHER MEDICAL/SURGICAL FACILITY