



# GROUP EXCESS MEDICAL

In-Hospital Statement of Claim



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

**PART 1 TO BE COMPLETED BY INSURED**

Name \_\_\_\_\_ Employed By \_\_\_\_\_

Address: \_\_\_\_\_ Town, State: \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

I authorize any individual of organization to release any information to First Rehabilitation Life Insurance Company of America for any services or benefits received or payable to me or on my behalf.

**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.**

Signature of Eligible Insured \_\_\_\_\_ Date \_\_\_\_\_

**PART 2 TO BE COMPLETED BY HOSPITAL IN LIEU OF BC / BS VOUCHER**

1. Name of Hospital \_\_\_\_\_

Location \_\_\_\_\_

2. Patient \_\_\_\_\_ Hospital No. \_\_\_\_\_  
Last Name First Name Middle Name

Age \_\_\_\_\_ Sex \_\_\_\_\_ If minor, Name of Guardian \_\_\_\_\_

3. Admitted (Date) \_\_\_\_\_ Discharge (Date) \_\_\_\_\_

Total Days Hospitalized \_\_\_\_\_

4. Was patient in Intensive Care Unit during hospitalization? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, furnish dates of such I.C.U. confinement

From \_\_\_\_\_ To \_\_\_\_\_

5. If patient is still hospitalized, please indicate expected duration of current hospitalization. \_\_\_\_\_

6. Diagnosis: \_\_\_\_\_

Date: \_\_\_\_\_ 19 \_\_\_\_\_  
Medical Records Librarian or Authorized Designee \_\_\_\_\_

**PART 3 TO BE COMPLETED BY: (BENEFITS ADMINISTRATOR)**

Name \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date: \_\_\_\_\_ Term Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_