BENEFIT REQUEST FORM

TYPE OR PRINT

PATIENT INFORMATION (TO BE COMPLETED BY EMPLOYEE)

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. EMPLOYEE'S NAME AND ADDRESS

FULL TIME STUDENT
☐ YES ☐ NO IF YES, WHERE

4. PATIENT'S ADDRESS *(if different from employee)*

5. PATIENT'S SEX
☐ MALE ☐ FEMALE

6. EMPLOYEE'S SOC. SEC. NO.

7. PATIENT'S RELATIONSHIP TO INSURED
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

8. GROUP NAME *(e.g. employer)*

9. OTHER HEALTH INSURANCE COVERAGE - ☐ YES ☐ NO
If Yes, Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
☐ YES ☐ NO
B. AN ACCIDENT
☐ YES ☐ NO

11. IF AN ACCIDENT
date_____ 19____ and time_____ ☐ A.M. ☐ P.M.
description (how & where) _____

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the Release of any Medical Information Necessary to Process this request.
SIGNED *DATE*

13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.*
SIGNED (Employee or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO EMPLOYEE)

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 WORK

18. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19. NAME OF REFERRING PHYSICIAN

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(if other than home or office)*

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

25. SIGNATURE OF PHYSICIAN OR SUPPLIER
SIGNED DATE

26.

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. YOUR SOCIAL SECURITY NO.

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & *TELEPHONE NO.*

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

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

* **PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY**