MEDICAL / DENTAL CLAIM FORM

PLEASE CHECK ONE	1. COMPLETE THIS FORM
☐ MEDICAL	2. ATTACH ITEMIZED BILLS
☐ DENTAL	3. MAIL TO PO Box 46511 Cincinnati, OH 45246-0511
☐ VISION	

GROUP HEALTH CDS
PO Box 46511
Cincinnati, OH 45246-0511
775-352-6900

PLEASE FILL OUT THE FOLLOWING INFORMATION

EMPLOYEE NAME	SOCIAL SECURITY #	EMPLOYEE BIRTHDATE	PHONE NO.

MAILING ADDRESS	CITY / STATE ZIP

PATIENT NAME (IF OTHER THAN EMPLOYEE)	MALE ☐ FEMALE ☐	RELATIONSHIP TO EMPLOYEE	PATIENT BIRTHDATE	IS PATIENT MARRIED? YES ☐ NO ☐

IS PATIENT FULL TIME STUDENT? YES ☐ NO ☐	NAME & ADDRESS OF SCHOOL	DATE ACCIDENT OR SICKNESS BEGAN

IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?	DID ACCIDENT HAPPEN AT WORK? YES ☐ NO ☐	HAS CLAIM BEEN FILED WITH WORKERS' COMP? YES ☐ NO ☐

NATURE OF SICKNESS, INJURY OR DIAGNOSIS	PHYSICIAN'S NAME

NAME OF SPOUSE	BIRTHDATE	IS SPOUSE EMPLOYED? YES ☐ NO ☐	NAME & ADDRESS OF SPOUSE'S EMPLOYER

ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP HEALTH PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR THE EXPENSES OF THIS CLAIM? YES ☐ NO ☐ IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF PLAN PROVIDING BENEFITS.

POLICYHOLDER: _____

NAME AND ADDRESS: _____

_____

SOCIAL SECURITY NO. _____

POLICY NO. _____

EFFECTIVE DATE: _____

PATIENT OR PARENT MUST SIGN BELOW

AU7THORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify this information provided is correct and true to the best of my knowledge.

X _____
Covered Person Date

IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PROVIDER(S):

I hereby authorize payment of benefits to any provider of service, otherwise payable to me for service, but not to exceed the reasonable and customary charges for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X_____
Covered Person Date