STATEMENT OF CLAIM

INSTRUCTIONS FOR FILING CLAIM
WHEN YOU HAVE INCURRED MEDICAL EXPENSES
COVERED BY YOUR GROUP PLAN:

Med-Pay, Inc.
P.O. Box 10909
Springfield, MO 65808
(417) 886-6886
1-800-777-9087

1. Complete the Employee's Statement
2. Attach the bills for the medical expense benefits you are claiming.

   The bills must show the:
   - Patient's name
   - Condition being treated (Diagnosis)
   - Type of treatment given
   - Date the expense was incurred
   - Charges made

   A Physician's Statement is provided on the other side of this form (Physician or Supplier Information Section) if the provider prefers to use it instead of a separate itemized billing (such as on a HCFA 1500 form).
3. If you are filing your first claim for services rendered in the pre-existing conditions exclusionary period, please attach a list of the NAMES AND COMPLETE MAILING ADDRESSES of all doctors and pharmacies who have provided treatment or prescriptions in the previous two years. The pre-existing conditions exclusionary period may be reduced with creditable coverage from prior health plans. If you have not submitted a copy of the creditable coverage certificate, please send it with your doctor/pharmacy list. You may request a copy of this certificate from your prior health plan's customer service department.
4. Mail claim directly to Claim Supervisor (Med-Pay, Inc.) at the address on your ID card unless the ID card states otherwise.

Southwest Missouri State
U N I V E R S I T Y

Employee Benefit Plan
Plan #090188SMSU

EMPLOYEE'S STATEMENT

PART 1

Fully Complete For All Claims

Employee's Name (Please Print)	☐ Male ☐ Female	Plan No.	Your Date of Birth	Social Security Number

Address: Street and No.	City	State	Zip Code

☐ Active ☐ Retired | This claim is on: ☐ Myself ☐ My Spouse ☐ Dependent Child

Are you married? ☐ Yes ☐ No If yes, give spouse's information below:

Name of Spouse ______________________ Spouse's Date of Birth ______________

Name of Spouse's Employer ______________________ Address ______________

Nature of sickness or injury for which claim is made	Date last worked	Date sickness began	Date of first expense for this condition

Are any of the expenses for which this claim is being made covered by any other group insurance, group Blue Cross/Blue Shield, Medicare, Medicaid, Veterans or union welfare plan? (Including any insurance or coverage carried by a dependent.) ☐ Yes ☐ No

If yes, give the name and address of the insurance company and/or organization providing such benefits.

Name ______________________ Address ______________________

Policy Number or Contract Number ______________________

Complete For All Injuries Employee or Dependent

Date of the injury	Where did the injury occur?	How did the injury occur? Is injury due to automobile accident? ☐ Yes ☐ No

Is this a work related injury? ☐ Yes ☐ No Has or will claim be filed under any Workmen's Compensation Act or similar law? ☐ Yes ☐ No

Complete Only For Dependent Claims

Name of Dependent	Sex	Date of Birth	Relationship of Dependent	☐ Married ☐ Single

Date this dependent became covered	If employed or attending school give the name of employer or school and dependent's Social Security Number

Sign Here

I HEREBY AGREE TO REIMBURSE MY EMPLOYER TO THE EXTENT OF ANY OVERPAYMENT WHICH IS IN EXCESS OF THE AMOUNT PAYABLE UNDER THE PLAN. THE STATEMENTS ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY BELIEF. I AUTHORIZE ANY HOSPITAL OR PHYSICIAN TO FURNISH ANY INFORMATION REQUESTED. ALSO, I HEREBY AUTHORIZE MY EMPLOYER OR MED-PAY, INC., TO RELEASE OR OBTAIN FROM ANY ORGANIZATION OR PERSON ANY INFORMATION WHICH MAY BE NECESSARY TO DETERMINE BENEFITS PAYABLE UNDER THE PLAN WITH MY EMPLOYER. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

X ______________________

EMPLOYEE'S SIGNATURE **DATE** **PATIENT'S SIGNATURE**

HEALTH BENEFIT CLAIM FORM

TYPE OR PRINT

PATIENT & PLAN MEMBER INFORMATION (COMPLETE PART 2 FOR ASSIGNMENT OF BENEFITS)

PART 2

1. PATIENT'S NAME *(First name, middle initial, last name)*
2. PATIENT'S DATE OF BIRTH
3. PLAN MEMBER'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. or **MEDICARE NO.** *(Include any letters)*
7. PATIENT'S RELATIONSHIP TO PLAN MEMBER — SELF / SPOUSE / CHILD / OTHER
8. PLAN NUMBER *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE *(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 AUTO ACCIDENT — YES / NO
11. PLAN MEMBER'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.
    SIGNED DATE
13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN OR SUPPLIER FOR SERVICES.*
    SIGNED *(Plan Member or Authorized Person)*

PHYSICIAN OR SUPPLIER INFORMATION (PART 3 NECESSARY ONLY IN THE ABSENCE OF ITEMIZED STATEMENT FROM PHYSICIAN OR SUPPLIER)

PART 3

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 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. ACCEPT ASSIGNMENT — YES / NO
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.
    I.D. 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

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74