Medical Claim Form

Professional Benefit Administrators

Send all bills to:
Professional Benefit Administrators, Inc.
P.O. box 4687, Oak Brook, IL 60522
(800) 435-5694
Pbaclaims.com

Instructions for Completing the Claim Form

- Only complete this form when you are submitting a claim for reimbursement.
- A fully completed claim form is required with the first claim submission of each calendar year. Additional claim submissions do not require the completion of this form unless your claims are the result of a new accident.
- A fully completed claim form is required with dependent claim submissions every six months.
- If you wish to have your benefits paid directly to your physician or hospital, please sign part D below.
- After completing the front side of this claim form, please see additional instructions on the reverse side

Part A – Employee Information

Employer name:		
Employee name:	**Date of birth:**	**ID #:**
Home Address:		**Phone:**
Sex: ☐ M ☐ F	**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed	
Spouses Name:	**Date of birth:**	**ID #:**
Is Spouse Employed? ☐ Yes ☐ No	If yes, Company Name:	
Address:		**Phone:**

Part B – Dependent Information

Name:	**Relationship:**	**Date of birth:**
Home address if different from employee:		
Is dependent employed? ☐ Yes ☐ No	**Name of Employer:**	
Address:		**Phone:**

If claim is for child over 19 indicate:

A. **Student** ☐ Full-time ☐ High School ☐ Vocational ☐ College
Credit hours of study: _____ Name & Address of School: _____

B. **Handicapped**, Please Explain: _____

Are you or your dependents entitled to benefits from any other group insurance plan including Blue Cross, Blue Shield, or governmental programs including **MEDICARE?** ☐ Yes ☐ No
Is the other plan an HMO? ☐ Yes ☐ No

A. Identify Family members insured under other plan:
B. Name(s) and addresses of other insurance company and/or organization:
C. Group policy number:

Part C – Claim Information

This claim is for: ☐ Self ☐ Spouse ☐ Unmarried Child Under 19	Other:		
Claim is for: ☐ Sickness/Condition	**Briefly Explain:**		**Date of Symptoms:**
☐ Accident	**Date/Time:**	**Where:**	
Explain what happened:			
Did sickness or injury arise out of or in the course of any employment? ☐ Yes ☐ No			
If yes, explain (include employer's name):			

CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION: I certify that these statements and answers are true to the best of my knowledge and belief. I hereby agree to reimburse this plan to the extent that benefits are provided under any Workers' Compensation law, similar legislation, and/or any settlement related to such coverages.

I hereby authorize any insurance company, provider, or any other organization to release all information to PBA, Inc., which may have a bearing on the benefits payable under this plan. A photocopy of this authorization will be considered as effective and valid as the original, and will be valid for one year from the date below.

Date:	**Employee Signature:**	**Spouse Signature** (if claim is on spouse)**:**

Part D – Assignment Authorization

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits, if any to the provider of services on the reverse side of this form and for those providers whose billings are attached to this form.	
Signed (Employee):	**Date:**

PLEASE SUBMIT ORIGINAL BILLS AND KEEP COPIES FOR YOUR RECORDS

Instructions for Submitting Claims with this Form

- Your physician must complete part E below, unless you have itemized bills, which can be attached to this form. (Itemized bills must show the patient's name, date, and type of service, amount charged, diagnosis, and provider's Social Security or Federal Tax ID number.)

Part E – Attending Physician Statement

Date of illness (first symptom) Or injury (accident) Or pregnancy (LMP)	**Date consulted for This condition:**	**Has patient ever had same or similar symptoms?** ☐ Yes ☐ No Year?
Date patient able to return to work:	**Date of total disability:** From: Through:	**Date of partial disability:** From: Through:
Name of referring physician:		**For services related to hospitalization give hospitalization dates:** Admitted: Discharged:
Name & address of facility where services rendered (if other than home or office):		**Was laboratory work performed outside of your office?** ☐ Yes ☐ No Charges:

Diagnosis or nature of illness or injury. Related diagnosis to procedure in column ICD9 (see below) by reference number 1,2,3, ETC. or DX code.

1.

2.

3.

4.

A Date of service	B * Place of service	Cpt code (identify)	C Fully describe procedures, medical services, or supplies furnished for each date given (explain unusual services or circumstances)	D ICD9CM Code	E Charges	F ** T.O.S.	

Your patient's account no. if you wish to identify on check. I do not accept assignment. ☐	Total Charge	Amount paid	Balance Due

Does patient have other health coverages? ☐ Yes ☐ No If yes, please identify:

Date	**Physicians name (please print)**	**Degree**	Individual practitioner's SS# Must be furnished under authority of law
Physician's signature		**Phone**	All other employer ID #'s Must be furnished under authority of law
Street address	**City or Town**	**State or Province**	**Zip Code**

***PLACE OF SERVICE CODES:**

11 - Office
12 - Home
21 - Inpatient Hospital
22 - Outpatient Hospital
23 - Emergency Room (Hospital)
24 - Ambulatory Surgical Center
25 - Birthing Center
31 - Skilled Nursing Facility
32 - Nursing Facility
33 - Custodial Care Facility
34 - Hospice
41 - Ambulance (land)
42 - Ambulance (air or water)
51 - Inpatient Psych. Facility
52 - Psych Facility – Partial Hospitalization
53 - Community Mental Health Center
54 - Intermediate Care Facility – Ment. Ret.
55 - Residential Sub. Abuse Treatment Fac.
56 - Psych Residential Treatment Center
61 - Comp. Inpatient Rehab. Facility
62 - Comp. Outpatient Rehab. Facility
65 - End Stage Renal Disease Treatment Fac.
71 - State or Local Public Health Clinic
72 - Rural Health Clinic
81 - Independent Laboratory
99 – Other Unlisted Facility

****TYPE OF SERVICE CODES:**

1 - Medical care
2 - Surgery
3 - Consultation
4 - Diagnostic X-ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other medical service
0 - blood or Packed Red Cells
A - Used DME
M - Alternate Payment for Maintenance Dialysis
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

This plan is administered by Professional Benefit Administrators, Inc. P.O. Box 4687, Oak Brook, IL 60522-4687 (800) 435-5694