



DELTA HEALTH SYSTEMS

REFER TO YOUR I.D. CARD FOR PROPER MAILING ADDRESS

EMPLOYEE ID NUMBER

____ - _____

EMPLOYEE SOCIAL SECURITY NUMBER

____ - ____ - _____

MEDICAL CLAIM FORM

PATIENT AND EMPLOYEE INFORMATION

1. PATIENT'S NAME		2. PATIENT'S DATE OF BIRTH		3. EMPLOYEE'S NAME	
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. EMPLOYEE'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	
		7. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		<input type="checkbox"/> CHECK HERE IF NEW ADDRESS	
8. OTHER HEALTH INSURANCE COVERAGE IS PATIENT COVERED BY ANY OTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE NAME AND ADDRESS OF CARRIER: _____ IDENTIFICATION OR SOCIAL SECURITY NUMBER _____ NAME OF EMPLOYER _____ TYPES OF COVERAGE BY CARRIER: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DRUG <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION EFFECTIVE DATE OF COVERAGE _____ TERMINATION DATE OF COVERAGE _____					
9. I AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____			10. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW. SIGNED (EMPLOYEE OR PATIENT) _____ DATE _____		

PHYSICIAN OR SUPPLIER INFORMATION

11. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		12. DATE FIRST CONSULTED YOU FOR THIS CONDITION		13. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. WAS CONDITION RELATED TO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF ACCIDENT RELATED, PLEASE GIVE DETAILS: _____					
15. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE AND ADDRESS			16. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		
17. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED			18. WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO CHARGES _____		
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D			PLACE OF SERVICE CODES* 1 - INPATIENT HOSPITAL 6 - NIGHT CARE FACILITY(PSY) B - AMB SURG CTR 2 - OUTPATIENT HOSPITAL 7 - NURSING CARE C - RESID TREAT CTR 3 - DOCTOR'S OFFICE 8 - SKILLED NURSING FAC D - SPECIALIZED TREAT CTR 4 - PATIENT'S HOME 9 - AMBULANCE E - COMP O/P REHAB 5 - DAY CARE FACILITY(PSY) A - INDEPENDENT LAB F - IND KIDNEY DISEASE TREAT CTR		
20. A DATE OF SERVICE FROM TO		B* PLACE OF SERVICE		C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN CPT-4 PROCEDURE CODE (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	
				D DIAGNOSIS CODE	
				E CHARGES	
				F DAYS OR UNITS	

21. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) DATE: _____		22. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) <input type="checkbox"/> YES <input type="checkbox"/> NO		23. TOTAL CHARGES		BALANCE DUE	
26. YOUR PATIENT'S ACCOUNT NUMBER		24. YOUR TAX IDENTIFICATION NUMBER		25. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER			
		27. TAXABLE ENTITY NAME (IF DIFFERENT THAN BOX 25)					