STATEMENT OF MEDICAL CLAIMS

WHEN COMPLETED RETURN TO:
Carolina Care Plan, Inc.
P.O. Box 100234
Columbia, SC 29202-3234

TO BE COMPLETED BY INSURED

A. INSURED (SUBSCRIBER) INFORMATION

1. Insured's Name

Residence Address | Apt. No. | City | State | Zip Code

2. Telephone | 4. Marital Status

3. Employer | 5. Spouse's Name

6. Name and address (city) of spouse's employer (if employed)

B. PATIENT INFORMATION

7. Patient's Name

8. Patient's Date of Birth | 9. Patient's Relationship to Employee | 10. Member ID # (stated on ID card)

11a. Describe Illness or Injury: | 11b. Date It Began

11c. Was this due to an auto accident? ☐ Yes ☐ No | 11e. Was this due to a dental injury? ☐ Yes ☐ No

11d. If injury, was it job related? ☐ Yes ☐ No | 11f. Was this an emergency? ☐ Yes ☐ No

(Please explain)

12a. Do you or any member of your immediate family have any other group insurance which may cover all or part of this claim? ☐ Yes ☐ No | 12b. If yes, give insurance company name, address, and group number

13. Assignment: Please pay provider directly, I have assigned benefits. ☐ Yes (if yes, sign below) ☐ No

Insured's Signature | Date

C. AUTHORIZATION

I certify that the above statements are true and correct to the best of my knowledge and hereby authorize any physician, hospital, employer, union, insurance company, HMO, or prepayment organization to supply each other any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original. Under Indiana law, submitting a false claim with intent to defraud is a Class D felony.

X

Insured's Signature | Date Signed

Please check to see that both sides of this claim form have been properly completed and signed.

D. FRAUD WARNING

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

HEALTH INSURANCE CLAIM FORM

Read Instructions Before Completing or Signing This Form

TO BE COMPLETED BY PROVIDER

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE CONDITION BEGAN

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO

16A. IF AN EMERGENCY CHECK HERE

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 OR OTHER SOURCE (e.g., public health agency)

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

PRIOR AUTHORIZATION NO

24. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G T.O.S.	H LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER

(I certify that the statements on the reverse apply to this bill and are made a part hereof.)

SIGNED DATE

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) 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 AND TELEPHONE NO.

I.D. NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER I.D. NO.

REMARKS: