

# QualChoice/QCA

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## CLAIM FORM

**THIS FORM MUST BE COMPLETED BY EMPLOYEE**

### EMPLOYEE / EMPLOYER INFORMATION

EMPLOYER NAME \_\_\_\_\_  
EMPLOYEE NAME \_\_\_\_\_ I.D. NO: \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY & STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**I HEREBY PRESENT THIS CLAIM, and authorize any individual or organization to release information required for its acceptance.**

#### 1 CLAIM IS BEING MADE FOR:

- SELF                       UNMARRIED CHILD TO AGE 19  
 WIFE / HUSBAND         UNMARRIED FULL TIME STUDENT AGE 19 AND OVER, ATTENDING \_\_\_\_\_

2 PATIENTS NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

3 IS CLAIM DUE TO AN ACCIDENT? IF "YES", WHERE DID ACCIDENT OCCUR ? DATE OF ACCIDENT  
 YES     NO \_\_\_\_\_

DESCRIBE ACCIDENT:

4 IS THIS CLAIM THE RESULT OF A WORK RELATED ILLNESS OR INJURY ?  YES     NO    IF YES, PLEASE FILE WITH WORKERS' COMPENSATION CARRIER FIRST.

#### 5 IF MARRIED, IS YOUR WIFE/HUSBAND EMPLOYED?

YES     NO

NAME \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

#### 5a IF CLAIM IS FOR A DEPENDENT CHILD, IS THIS CHILD EMPLOYED?

YES     NO

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

#### 6 IS PATIENT ALSO COVERED FOR ANY OTHER INSURANCE BENEFIT AS LISTED BELOW, EITHER AS AN EMPLOYEE OR DEPENDENT?

YES     NO

If Yes, check box below which applies and complete 6a

- Group health insurance of any kind including Blue Cross and Blue Shield
- Coverage of medical care expenses provided by an employer, a union welfare plan, any federal, state, provincial or other governmental program.
- Other arrangements of benefits for individuals of a group

#### 6a GIVE NAME AND ADDRESS OF OTHER COMPANY OR ORGANIZATION PROVIDING INSURANCE:

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

OTHER INSURANCE OR BLUE CROSS/BLUE SHIELD GROUP NO.(s) \_\_\_\_\_

7 EMPLOYEE'S SIGNATURE \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_ DATE \_\_\_\_\_

COMMENTS: