MEDICAL CLAIM FORM

INSTRUCTIONS:

1. **Complete Employee's Statement below**
2. **Attached itemized bill**
3. **Please refer to your identification card for mailing instructions**

ncas®
The Team Approach to Benefit Administration

EMPLOYEE'S STATEMENT

NAME OF EMPLOYEE (*First name, middle initial, last name*)	EMPLOYEE'S BIRTH DATE	EMPLOYEE'S IDENTIFICATION NUMBER
EMPLOYEE'S ADDRESS (NO.) (STREET) (CITY) (STATE) (ZIP)		
EMPLOYEE'S SEX MALE ☐ FEMALE ☐ / EMPLOYEE'S MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED		EMPLOYER NAME **B. F. Saul Company**
EMPLOYEE'S SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO
NAME AND ADDRESS OF SPOUSE'S EMPLOYER		
IS COVERAGE FOR THIS CLAIM PROVIDED BY ANY OTHER GROUP INSURANCE, FEDERAL PROGRAM (INCLUDING MEDICARE), EMPLOYER, UNION, STUDENT OR ASSOCIATION PLAN? ☐ YES ☐ NO IF YES, PROVIDE NAME AND ADDRESS OF INSURANCE COMPANY POLICY NUMBER		
NAME OF PATIENT	PATIENT'S BIRTH DATE	PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
PATIENT'S SEX MALE ☐ FEMALE ☐ / IF CLAIM FOR A DEPENDENT CHILD, DO YOU HAVE LEGAL CUSTODY? ☐ YES ☐ NO IS CHILD MARRIED? ☐ YES ☐ NO IF OVER AGE 18, IS CHILD A FULL-TIME STUDENT AND DEPENDENT ON YOU FOR SUPPORT? ☐ YES ☐ NO		
NAME & ADDRESS OF SCHOOL ATTENDING		NUMBER OF CREDIT HOURS
DIAGNOSIS, NATURE OF ILLNESS OR INJURY		IS CONDITION RELATED TO EMPLOYMENT? ☐ YES ☐ NO
DATE OF ACCIDENT / HOW AND WHERE DID ACCIDENT HAPPEN?		
DATE AND NAME & ADDRESS OF PHYSICIAN FIRST CONSULTED		

ASSIGNMENT: I AUTHORIZE BENEFITS UNDER THIS CLAIM TO BE PAID DIRECTLY TO THE PROVIDER OF SERVICES PROVIDED THAT THE REQUIRED TAX ID NUMBER HAS BEEN FURNISHED.

DATE:_____ EMPLOYEE'S SIGNATURE: _____

AUTHORIZATION: The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, practitioner or other person, any hospital, including veteran's administration or government hospital, any medical service organization, any insurance company, or other institution, or organization, to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other liabilities. A photostat of this authorization shall be as valid as the original.

_____ _____ _____ _____

DATE EMPLOYEE'S SIGNATURE PATIENT'S SIGNATURE (PARENT OR GUARDIAN IF PATIENT IS A MINOR)