MEDICAL CLAIM FORM

INSTRUCTIONS

- Complete the Employee Statement below.
- Have your physician complete the reverse side.
- Attach all itemized bills and statements to this form and Mail to:

TPSC Benefits Claims Administrator:
P.O. Box 2950; Tacoma, WA 98401

Phone: 253.564.5611 ext. 210
Fax: 253.564.5881
Toll Free: 800.426.9786 ext. 210

EMPLOYEE STATEMENT

Last Name:		First Name:	M.I.:
Birth Date:		Social Security #:	
Address:		☐ Check if New Address	
City:	State:	Zip:	Phone #:
Date of Hire:	Sex: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single	
Name of Employer:		Group #:	
Job Position / Duties:			

Is coverage for this claim provided by any other group insurance, federal program (including medicare), employer union, Student or association plan? ☐ Yes ☐ No

Prescription: ☐ Yes ☐ No Vision: ☐ Yes ☐ No

If "yes", provide name and address of insurance company and policy number:

Name of Patient:		Birth Date:	
Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other:		Sex: ☐ Male ☐ Female	
If claim is for a dependent child, do you have legal custody?	☐ Yes ☐ No		
If over 18, is child a full-time student & dependent on you for child support?	☐ Yes ☐ No		
Name of School Attending:		Number of Credit Hours:	
Address:	City:	State:	Zip:

Diagnosis, nature of illness or injury:

Is condition related to employment? ☐ Yes ☐ No Date of Accident:

How & where did accident happen?

Name of physician first consulted for this illness or injury: Date of First Visit:

If you would like payment to be made to your provider, please sign and date below.

ASSIGNMENT: I AUTHORIZE BENEFITS UNDER THIS CLAIM TO BE PAID DIRECTLY TO THE PROVIDER OF SERVICES.

Date _____ Employee Signature _____

AUTHORIZATION: THE ABOVE ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY PHYSICIAN, SURGEON, 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 DISABILITIES. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date _____ Employee Signature _____ Patient Signature _____
(Parent or guardian if patient is a minor)

TPSC BENEFITS

MEDICAL CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT – HEALTH INSURANCE CLAIM

Patient's Name:		Age:
Address:	City:	State: Zip:
Employees name if patient is a dependent:		

1	**A)** diagnosis and concurrent conditions if fracture or dislocation, describe nature and location:	
	B) is condition due to injury or sickness arising out of patient's employment? If "yes" explain:	☐ Yes ☐ No
	C) is condition due to pregnancy? If "yes" what was appropriate date of commencement of pregnancy?	☐ Yes ☐ No Date:
2	**A)** When did symptoms first appear or accident happen?	Date:
	B) When did patient first consult you for this condition?	Date:
	C) Has patient ever had same or similar condition? If "yes" state when and describe:	☐ Yes ☐ No
3	**A)** Nature of surgical or obstetrical procedures, if any, include CPT codes:	
	B) Charge to patient for this procedure including post-operative care:	Date: $
	C) If performed in hospital, give name of hospital:	☐ Inpatient ☐ Outpatient
4	Give dates of other medical (nonsurgical) treatment, if any, include CPT codes:	**Charges Per Call:** Office $ Home $ Hospital $ Nursing Home $ **Total (nonsurgical) Charges** **$**
5	What other services, if any, did you provide the patient? Itemize, giving dates, CPT codes, and fees:	
6	Were registered private duty nurse (R.N.) services necessary?	☐ Yes ☐ No
7	Is patient still under your care for this condition? If "no", give date your services terminated:	☐ Yes ☐ No
8	**A)** How long was or will patient be continuously totally disabled *(unable to work)*?	From: Thru:
	B) How long was or will patient be partially disabled?	From: Thru:
	C) Was house confinement necessary? If "yes", give dates:	☐ Yes ☐ No From: Thru:
9	To your knowledge, does patient have other health insurance or health plan coverages? If "yes", identify:	☐ Yes ☐ No

Date	Signature *(Attending physician and degree)*
Phone #:	IRS Identifying #:
Street Address: City or Town: State: Zip Code:	

Send completed form, together with itemized bills, to:

TPSC Benefits Claims Department
P.O. Box 2950
Tacoma, WA 98401