**FOR AMWINS CONNECT ADMINISTRATORS USE ONLY:**

Effective Date of Insurance For
Employee _____ Date of Termination_____
Dependent _____ Initials _____

# MEDICAL /VISION CLAIM FORM

AMWINS™
CONNECT ADMINISTRATORS

## Section A — To be Completed by Employee or Surviving Spouse

| Employee's Name (Please Print Full Name) | Emp. Date of Birth | Employee's Identification Number | Employer Name |
|---|---|---|---|
| | | | |

| Home Address | ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Legally Separated ❑ Domestic Partner | First Name of Spouse | Is your Spouse Employed? |
|---|---|---|---|
| No. Street | Name and Address of company where spouse is employed | | |
| City State Zip | Spouse's Date of Birth | Spouse's Identification Number | |

Has your employment terminated? ❑ Yes ❑ No  Are you currently on a leave of absence? Yes No  If yes, date _____

Is patient also covered for benefits by any

| | | |
|---|---|---|
| a. Other Group Health insurance of any kind including Blue Cross and Blue Shield? | Yes | No |
| b. Group prepayment arrangement, including HMO, providing for medical care and treatment? | Yes | No |
| c. Coverage of medical care expenses provided by a school, or by Medicare / Medicaid or other federal, state, provincial or government agency? | Yes | No |
| d. No fault automobile insurance as a result of injuries sustained in automobile accident? | Yes | No |

***If any of the above are answered "Yes" please Indicate under "Remarks" the other insurance company's name and policy number, the employee's or dependent's ID or SS number and the name and address of the school, employer, union or government agency.***

Was illness or injury due, in any way

| | | |
|---|---|---|
| a. To the patient's occupation | ❑ Yes | ❑ No |
| b. To an automobile accident | ❑ Yes | ❑ No |
| c. Any other type of accident | ❑ Yes | ❑ No |

***If any of the above are answered "Yes" give details under "Remarks". If an accident was involved, include date of accident and extent of injuries• For automobile accident Include state in which it occurred.***

At the time charges were incurred:
Was your spouse employed? ❑ Yes ❑ No
If a claim is for a child was the child employed? ❑ Yes ❑ No

If the answer to either is "Yes", please show in "Remarks" the names of the persons employed, and the name and address of their respective employers.

Is the patient eligible for Medicare? ❑ Yes ❑ No  If *yes,* effective dates: Part A _____ Part B_____ Part D(RX)_____

Remarks:

Describe Condition(s) Being Treated:

## Dependent Information/Complete Section only if Patient is a Dependent

| Name of dependent | Date of birth Month / Day / Year | Relationship ❑ Spouse ❑ Child Other _____ (relationship) | Marital status if other than spouse: ❑ Single ❑ Divorced ❑ Widowed ❑ Married ❑ Domestic Partner |
|---|---|---|---|
| | | | |

| If a claim is for dependent child 19 or older, is child enrolled as a full-time student? ❑ Yes No | Name of school | Sex: ❑ Male ❑ Female |
|---|---|---|
| | | |

If dependent (other than spouse) is age 19 or over: (a) is that individual wholly dependent upon you for support or maintenance? ❑ Yes ❑ No
(b) is that individual disabled? ❑ Yes ❑ No

| Nature of Illness | Number of Bills attached | Covers period From | To | Total charges |
|---|---|---|---|---|
| | | | | |

AUTHORIZATION OF PAYMENT TO: ❑ EMPLOYEE ❑ PROVIDER

## IMPORTANT: THE FOLLOWING AUTHORIZATION MUST ALSO BE COMPLETED

To all physicians, hospitals, medical service providers, druggists, employers and any other agencies or organizations (including other insurance companies, Blue Cross-Blue Shield and prepaid health plans).
For purposes of evaluating a claim, you are authorized to permit Amwins Connect Administrators and its authorized representatives to view or obtain a copy of all existing records (including those of psychiatric, drug or alcohol treatment) pertaining to the examination, medical and dental treatment, history, prescriptions, employment and insurance coverage)

I hereby certify that the above statements and attachments are correct and represent actual services, dates and fees charged to me or my eligible dependents.

Employee signature  Date

### HOW TO FILE YOUR CLAIM

ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE SUBJECT TO CRIMINAL PENALTIES.

1. COMPLETE SECTION A. ANSWER ALL QUESTIONS. BE SURE TO INCLUDE YOUR IDENTIFICATION NUMBER.
2. HAVE YOUR DOCTOR COMPLETE SECTION B AND RETURN IT TO YOU FOR SUBMISSION TO YOUR CLAIM OFFICE, OR ATTACH AN ITEMIZED BILL.
3. ADDITIONAL MEDICAL BILLS: ATTACH THESE TO COMPLETED SUPPLEMENTAL MEDICAL CLAIM FORM AFTER INITIAL CLAIM SUBMISSION. A NEW DOCTOR'S STATEMENT IS NOT NECESSARY IF THE DIAGNOSIS OF THE CONDITION BEING TREATED IS ON THE BILL. A DETAILED BILL MAY BE INCLUDED IF YOU DO NOT FOLLOW "4" BELOW. SUBMIT ITEMIZED BILLS. DO NO SEND CANCELLED CHECKS, CASH REGISTER RECEIPTS, OR LISTS PREPARED BY YOU. THE ACTUAL BILLS ARE NEEDED. PRESCRIPTION BILLS MUST SHOW THE PHARMACY, PRESCRIPTION NUMBER, DATE OF PURCHASE AND THE NAME OF THE PERSON FOR WHOM DRUGS ARE PURCHASED. CHARGES SUBJECT TO A POLICY DEDUCTIBLE MAY BE ACCUMULATED, AND SUBMITTED WHEN THEIR TOTAL SATISFIES THE DEDUCTIBLE AMOUNT. YOU DO NOT HAVE TO SUBMIT EACH BILL AS IT IS INCURRED.
4. HOSPITAL ADMISSION: (OPTIONAL - SEE ABOVE) — COMPLETE SECTION A. PRESENT YOUR IDENTIFICATION CARD WITH YOUR FORM AND CLAIM OFFICE ENVELOPE TO THE HOSPITAL ADMISSIONS CLERK. ASK THE HOSPITAL TO RETURN THE FORM WITH A DETAILED HOSPITAL BILL TO YOUR CLAIM OFFICE. THE HOSPITAL MAY WISH TO CONTACT THE CLAIM OFFICE TO VERIFY YOUR COVERAGE. NOTE — IN CASE OF HOSPITAL CONFINEMENT, 2 FORMS MAY BE NEEDED, ONE EACH FOR THE HOSPITAL AND DOCTOR.
5. WHERE TO SEND YOUR CLAIM: SEND YOUR CLAIM TO THE CLAIM ADDRESS SHOWN ON THE BACK SIDE OF THIS FORM.

## Section B — Attending Physician's Statement

**PATIENT & INSURED (SUBSCRIBER) INFORMATION**

| 1. Patient's Name *(First name, middle initial, last name)* | 2. Patient's Date of Birth Mo. / Day / Yr. | 3. Insured's Name *(First name, middle initial, last name)* |
|---|---|---|
| | | |

| 12. Patient's or Authorized Person's Signature<br>I Authorize the Release of any Medical Information necessary to process this Claim<br>Signed / Date | 13. I authorize payment of medical benefits to undersigned physician or supplier for service described below<br>Signed |
|---|---|

**PHYSICIAN OR SUPPLIER INFORMATION**

| 14. Date of: Illness (First Symptom) or Injury (accident) or Pregnancy (LMP) 1 | 15. Date first consulted you for this condition | 16. Has patient ever had same or similar symptoms? Yes / No |
|---|---|---|

| 17. Date patient able to return to work From / Through | 18. Dates of total disability From / Through | Dates of partial disability From / Through |
|---|---|---|
| | | |

| 19. Name of referring physician | 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? |
|---|---|
| | |

23. Diagnosis or nature of illness or injury. relate diagnosis to procedure in Column D by reference to numbers 1, 2, 3, etc. or DX code

1.
2.
3.

| 24 A Date of Service | B POS Service | C Fully describe procedures, medical services or supplies furnished for each date given<br>Procedure Code (Identify: )<br>*(Explain unusual services or circumstances)* | D Diagnosis Code | E Charges | F |
|---|---|---|---|---|---|
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| 25 Signature of physician or supplier<br>Signed / Date | 26. Accept assignment (Government Claims only) (See Back)<br>Yes / No<br>30. Your Social Security No. | 27. Total charge | 28. Amount paid | 29. Balance due |
|---|---|---|---|---|
| | | | | |

| 32. Your Patient's Account No | 33. Your Tax Identification No. | 31. Physician's or supplier's Name, address, zip code & Telephone No<br>I.D. No. |
|---|---|---|
| | | |

'Place of Service Codes

1 — (IH) — Inpatient Hospital
2 — (OH) — Outpatient Hospital
3 — (0 ) — Doctor's Office
4 — (H) — Patient's Home
5 — Day Care Facility (PSY)
6 — Night Care Facility (PSY)
7 — (NH) — Nursing Home
8 — (SNF) — Skilled Nursing Facility
g — — Ambulance
0 — (OL) — Other Location
A — (IL) — Independent Laboratory
B — Other Medical/Surgical Facility

Send the completed Health Claim Form and itemized bills to:

Amwins Connect Administrators
Attention: Claims Department
P.O. Box 4368
Lutherville, MD 21094-9998
Toll Free: 800.337.4973
Fax: 410.584.9467
gbs.claims@amwins.com