

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 Employer	10. Member ID # (stated on ID card)
11a. Describe Illness or Injury:	11b. Date it Began	
	11c. Was this due to an auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	11e. Was this due to a dental injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
	11d. If injury, was it job related? <input type="checkbox"/> Yes <input type="checkbox"/> No	11f. Was this an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	12b. If yes, give insurance company name, address, and group number	
13. Assignment: Please pay provider directly, I have assigned benefits. <input type="checkbox"/> Yes (If yes, sign below) <input type="checkbox"/> No		
Insured's Signature		Date

C. AUTHORIZATION	
<p>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.</p>	
<p>X</p>	
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
<p>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.</p>

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 <input type="checkbox"/> NO <input type="checkbox"/>		16A. IF AN EMERGENCY CHECK HERE <input type="checkbox"/>	
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 <input type="checkbox"/> NO <input type="checkbox"/> CHARGES _____				
23. DIAGNOSIS									
								PRIOR AUTHORIZATION NO. _____	
24. A	B	C FULLY DESCRIBE PROCEDURES FURNISHED FOR EACH DATE GIVEN			D	E	F	G	H
DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE (IDENTIFY)	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES		DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	T.O.S.	LEAVE BLANK
25. SIGNATURE OF PHYSICIAN OR SUPPLIER <small>(I certify that the statements on the reverse apply to this bill and are made a part hereof.)</small>				26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE		28. AMOUNT PAID	29. BALANCE DUE
SIGNED _____ DATE _____				30. YOUR SOCIAL SECURITY NO.		31. PHYSICIANS OR SUPPLIERS NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. I.D. NO. _____			
32. YOUR PATIENT'S ACCOUNT NO.				33. YOUR EMPLOYER I.D. NO.					

REMARKS: