MEDICAL CLAIM FORM

PLEASE COMPLETE ONE CLAIM FORM PER PATIENT

Please complete an "Other Insurance and Dependent Coverage Questionnaire" at least once per year

1. Complete all questions

Check here if new address ☐

A. Employer Information

Name of Your Employer

Group number as shown on your ID Card

B. Employee Information

Last Name First Name MI

Employee's Social Security Number

Home Address

Employee's Birth Date

Month Day YR

City State Zip

Marital Status: Single ☐ Married ☐ Divorced ☐

C. Patient Information

Last Name First Name MI

Relationship to Employee
Self ☐ Spouse ☐ Child ☐

Patient's Birth Date

Month Day YR

If over 19, is child a full-time student? Yes ☐ No ☐
If yes, School attended:

Is Patient employed? Yes ☐ No ☐
If Yes, Name of Employer:

Is Spouse employed? Yes ☐ No ☐
If Yes, Name of Employer:

2. Complete the sections which apply to your claim

D. Complete if Patient is covered under any other health plan

Other Group Plan Name

Identification / Policy Number

Insurance Company Name and Address

City State Zip

E. Accident or work related injury Information

Is claim due to an accident?
Yes ☐ No ☐

If "yes," where did the accident occur?

Date of accident

Month Day YR

Describe Accident

Is this claim the result of a work-related illness or injury? Yes ☐ No ☐

3. Assignment of Benefits

F. Complete only if you wish payment to be made directly to the provider of service

Name of Doctor, Hospital, or Other Medical Service Provider

City State Zip

Phone No.
( )

Employee's Signature Authorizing Direct Payment to Provider

Date

Month Day YR

4. Must be signed and dated by Employee

G. Authorization to release medical and insurance information

To any physician, medical practitioner, hospital, clinic or other medically related facility or provider of medical services or supplies, and any employer, group policyholder, or contract holder or insurer, I authorize you to release to TRISTAR Benefit Administrators, Inc. or to its representatives any and all information you may have about the mental and physical history, condition and treatment, and insurance coverage for the Patient named in Section C above.

I understand the information obtained by TRISTAR Benefit Administrators, Inc. will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by TRISTAR Benefit Administrators, Inc. to any person or organization EXCEPT to reinsuring companies, Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required or as I may further authorize. For the purpose of disclosing information, I understand that this authorization is valid for a period of one year. I know that I may request a copy of this authorization. If this authorization is given in connection with a claim for health benefit, disability, or life insurance benefits, I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.

I verify the above information is true and accurate.

Employee's Signature

Date

Month Day YR

ATTACH THE BILLS FOR THE MEDICAL EXPENSES YOU ARE CLAIMING. THE BILLS MUST BE ITEMIZED AND SHOW THE PATIENT'S NAME, DIAGNOSIS, TYPE OF TREATMENT, AND DATE OF SERVICE.

Please send the completed claim form and appropriate statements to:

TRISTAR BENEFIT ADMINISTRATORS
P.O. Box 65887
West Des Moines, IA 50265
800-456-4584

TO BE COMPLETED BY PHYSICIAN OR OTHER PROVIDER OF MEDICAL SERVICES

Please complete the following information or attach itemized bills, receipts, and statements of charges from all physicians, hospitals, and any other sources. These statements must contain the following:

A. Patient's name.
B. All services or supplies provided.
C. The charge for each service provided.
D. The date each service or supply was provided.
E. Diagnosis or illness involved.

PROVIDER OF SERVICE

Date of	Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Date First Consulted You for This Condition	Has patient ever had same or similar symptoms? Yes ☐ No ☐
Date Patient Able to Return to Work	Dates of Total Disability From Through		Dates of Partial Disability From Through
Name of Referring Physician			For Services related to hospitalization give dates Admitted Discharged
Name & address of facility where services rendered *(if other than home or office)*			Was laboratory work performed outside your office? Yes ☐ No ☐

Diagnosis or nature of injury.
1.
2.
3.
4.

Date of Service	Place of Service*	Procedure Code CPT-4	Fully describe procedures, medical services, or supplies furnished for each date given. (Explain unusual services or circumstances)	ICD9 Diagnosis Code	Charges	

Signature of Physician or Supplier	Accept Assignment Yes ☐ No ☐	Total Charge	Amount Paid	Balance Due
Signed Date	Employer SS Number or	Physician's or Supplier's Name, Address, Zip Code, and Telephone No.		
Patient Account Number	Employer T.I.N. Number	I.D. No.		

Complete	Date of Purchase	Prescription Number	Name of Medication	Diagnosis for Which Medicine was Prescribed	Prescribing Physician	Cost *(Excluding Tax)*
Each						
Column						
For						
Each						
Prescription						