

HEALTH BENEFIT CLAIM FORM

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**Keenan**

HealthCare  
P.O. Box 2744  
Torrance, CA 90509  
1-877-ENLOE 99  
1-877-365-6399

**PLEASE COMPLETE PART 1, 2 AND 3 OF THIS FORM IN DETAIL**

**HOW TO FILE A CLAIM**

- Complete your portion of this "Claim Form". Be sure to answer all questions to avoid delay in payment of benefits.
- Attach an itemized statement of charges, nature of service as well as date and amount charged for each.
- Each bill or statement must show (1) Insured's Name (2) Patient's Name (3) Diagnosis or,
- Ask your doctor to complete the "Attending Physician's Statement" portion of this form.

**WHERE TO FILE A CLAIM** *Keenan HealthCare*, Benefit Claims Department, P.O. Box 2744, Torrance, CA 90509

**EMPLOYEE INFORMATION**

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EMPLOYEE'S NAME		MALE/FEMALE	DATE OF BIRTH / /	EMPLOYEE SS# or ALTERNATE ID#:	
EMPLOYEE'S STREET ADDRESS		CITY	STATE	ZIP CODE	HOME TELEPHONE NUMBER
YOUR OCCUPATION		NAME OF FACILITY WHERE EMPLOYED			
ARE YOU MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF SPOUSE	DATE OF BIRTH / /	NAME AND ADDRESS OF SPOUSE'S EMPLOYER		
IS THE PATIENT, OR ANY FAMILY MEMBER ENROLLED IN AN HMO, PPO OR COVERED UNDER ANY MEDICAL, OR OTHER GROUP INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, GIVE NAME AND ADDRESS OF HMO, PPO FACILITY, EMPLOYER OR OTHER GROUP INSURANCE CO.			

**DEPENDENT INFORMATION**

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IS CLAIM FOR A DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF DEPENDENT, IF OTHER THAN SPOUSE	DEPENDENT'S RELATIONSHIP TO EMPLOYEE
DEPENDENT'S DATE OF BIRTH / /	IS THIS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF DEPENDENT IS A FULL-TIME STUDENT, GIVE NAME/ADDRESS OF SCHOOL
IS DEPENDENT EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GIVE NAME AND ADDRESS OF EMPLOYER	

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IS THIS CLAIM DUE TO AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE OF ACCIDENT	WAS A MOTOR VEHICLE INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID THIS ACCIDENT OCCUR DURING YOUR COURSE OF EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		WHERE DID THIS ACCIDENT HAPPEN?
DESCRIBE HOW THE ACCIDENT HAPPENED:		

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I certify the above is complete and correct and I am claiming benefits only for charges incurred by the patient named above.

Authorization is hereby given to any hospital, physician, or other provider that participated in any way with the care and treatment, insurance company including a prepaid health plan, employer or group policyholder, contract holder or benefit plan administrator, to release to the above named Plan Administrator any medical information and any employment information regarding the patient, which they in their judgement deem necessary to evaluate and administer claim benefits.

I know I have a right to receive a copy of this authorization and that its photographic copy is as valid as the original.

SIGNATURE (PATIENT, OR PARENT IF MINOR)	DATE
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**★ INSTRUCTION FOR PROVIDER(S) OF MEDICAL CARE ★**

**SEND TO: Keenan HealthCare, Benefits Claims Department, P.O. Box 2744, Torrance, CA 90509**

**NOTE: IF YOU HAVE A DOCTOR'S BILL CONTAINING THE INFORMATION REQUESTED BELOW, YOU MAY ATTACH IT TO THIS FORM RATHER THAN COMPLETING THE FORM ITSELF.**

**AUTHORIZATION TO PAY PROVIDER:** I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER OF ANY BENEFITS OTHERWISE PAYABLE TO ME UNDER THE PLAN.

EMPLOYEE'S SIGNATURE	DATE
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**ATTENDING PHYSICIAN'S STATEMENT (TO BE COMPLETED BY ATTENDING PHYSICIAN OR SUPPLIER OF SERVICES)**

PATIENT'S NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH / /	RELATIONSHIP TO EMPLOYEE	EMPLOYEE'S SOCIAL SECURITY NO.
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WAS CONDITION RELATED TO: <input type="checkbox"/> PATIENT'S EMPLOYMENT <input type="checkbox"/> AN AUTO ACCIDENT <input type="checkbox"/> PREGNANCY	HAVE YOU COMPLETED ANY OTHER CLAIM FORMS FOR THIS ILLNESS OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU HAVE ANY KNOWLEDGE OF THE PATIENT HAVING OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE IDENTIFY
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DATE OF 1 <sup>ST</sup> SYMPTOM OR ACCIDENT	WAS LABORATORY WORK PERFORMED OUTSIDE OF YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO	CHARGE \$ _____
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DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?	NAME AND ADDRESS OF REFERRING PHYSICIAN
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FOR SERVICES RELATED TO HOSPITALIZATION:	DATE ADMITTED	DATE DISCHARGED	NAME AND ADDRESS OF FACILITY
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DATE(S) OF TOTAL DISABILITY:	FROM: THROUGH:	DATE PATIENT IS ABLE TO RETURN TO WORK
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DIAGNOSIS (ICD-9-CM) (IF MORE THAN ONE CONDITION, PLEASE RELATE DIAGNOSIS TO PROCEDURE(S) USING ICD-9-CM CODE(S) TO FIFTH DIGIT IF APPLICABLE)

IF MORE THAN ONE CONDITION, PLEASE RELATE DIAGNOSIS TO PROCEDURE(S) USING ICD-9-CM CODE	<b>PLACE OF SERVICE CODES:</b> IH - INPATIENT HOSPITAL OH - OUTPATIENT HOSPITAL O - DOCTOR'S OFFICE	H - PATIENT'S HOME NH - NURSING HOME SNF - SKILLED NURSING FACILITY	OL - OTHER LOCATIONS IL - INDEPENDENT LABORATORY
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DATE OF SERVICE	DIAGNOSIS CODE	PLACE OF SERVICE	DESCRIPTION OF SERVICE	PROCEDURE CODE (CPT-4)	CHARGES

PHYSICIAN'S OR SUPPLIER'S NAME	SOCIAL SECURITY NO.	TOTAL CHARGE \$
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STREET ADDRESS	EMPLOYER/TAX IDENTIFICATION NO.	AMOUNT PAID \$
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CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )	BALANCE DUE \$
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SIGNATURE OF PHYSICIAN OR SUPPLIER	DATE
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