EMPLOYER _____ CLAIM NO. _____

ISLAND GROUP ADMINISTRATION, INC.
HEALTH BENEFIT CLAIM FORM
3 TOILSOME LANE, EAST HAMPTON, NY 11937-6046
LOCAL (631) 324-2306 / OUT OF AREA (800) 926-2306

*** TO BE COMPLETED BY EMPLOYEE ***

EMPLOYEE SOCIAL SECURITY # _____ - _____ - _____

EMPLOYEE'S NAME _____

EMPLOYEE'S ADDRESS _____

EMPLOYEE'S PHONE # (HOME) _____ (WORK) _____

1. Patient's Name: _____
2. Patient's Address: _____
   street city state zip
3. Patient's Date of Birth: _____ Sex: ☐MALE ☐FEMALE
4. Patient's relationship to employee: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
5. Was condition related to:
   (A) PATIENT'S EMPLOYMENT ☐YES ☐NO
   (B) AUTOMOBILE ACCIDENT ☐YES ☐NO
   (C) OTHER ☐YES ☐NO
6. IF YOU ANSWERED YES TO #5 A, B or C, answer the following:
   A. When did the accident occur? _____, 19_____ AT _____ A.M./P.M.
   B. Where did the accident happen? _____
   C. Brief description of accident _____
   _____
7. Is patient covered by other health insurance? ☐YES ☐NO
8. Name of other health plan _____
9. Is patient covered by MEDICARE or MEDICAID? ☐YES ☐NO

*** DEPENDENT INFORMATION ***

IF PATIENT IS A STUDENT OVER AGE 19, PLEASE ANSWER THE FOLLOWING:

1. Name of school and date enrolled _____
2. Except for regular vacation periods, was student enrolled during the entire period covered by this claim? ☐YES ☐NO
3. Have you provided a TUITION STATEMENT for the period covered by this claim? ☐YES ☐NO

IF NO, PLEASE ATTACH THE TUITION STATEMENT TO THIS CLAIM FORM.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM

_____

SIGNATURE OF EMPLOYEE OR GUARDIAN DATE

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN OR SUPPLIER OF SERVICES: ☐YES ☐NO

_____

SIGNATURE OF EMPLOYEE OR GUARDIAN DATE

*ATTACH A COMPLETE PHYSICIAN/HOSPITAL BILLING TO THIS CLAIM FORM **OR** HAVE A PHYSICIAN COMPLETE BACK OF THIS CLAIM FORM.

* TO BE COMPLETED BY PHYSICIAN OR SUPPLIER *
IN ABSENCE OF COMPLETED BILLING

1. Patient's Name: _____
2.

A Date of Svc.	B Place of Svc.	C Fully describe procedures, medical services or supplies; furnished for each date given	D Diagnosis Code	E Charges	F
		Procedure Code (Identify:) (Explain unusual services or circumstances)			

3. Date first consulted for this condition _____
4. Has patient ever had same/similar symptoms? □ YES □ NO
5. Was laboratory work performed outside your office? □ YES □ NO
6. Dates of total disability: from _____ through _____
7. Date patient able to return to work? _____
8. For services related to hospitalization:
   Date Admitted _____ Date Discharged _____
9. Name of referring physician _____
10. Accept assignment □ YES □ NO
11. Patient's Account Number _____
12. TOTAL CHARGES $_____ AMOUNT PAID $_____ BALANCE DUE $_____

Physician/Supplier Name _____

Physician/Supplier Tax I.D. # _____

Physician/Supplier Phone # (_____) _____

Physician/Supplier Address _____

_____

SEND THIS COMPLETED FORM AND A COPY OF THE BILL TO:

ISLAND GROUP ADMINISTRATION, INC.
3 TOILSOME LANE
EAST HAMPTON, NY 11937-6046

ISLAND GROUP ADMINISTRATION, INC.
ISLAND GROUP