MEDICAL CLAIM FORM

Instructions for making a claim for benefits:
1. Answer all required questions on this form and sign it
2. If you want PHPC to pay the hospital or doctor directly you will need the paper copy
3. Attach your receipt(s)

Preferred Health Plan of the Carolinas
Third Party Administrator
PO Box 220397
Charlotte, NC 28222
(866)636-0239 or (704) 847-2321

Employer Name	Group or Plan Number	Personal Identification Number	Daytime Phone Number

Employee Name	Address	City	State	Zip Code

Date of Birth	Martial Status	Work Status
	⎕ Single ⎕ Married ⎕ Divorced ⎕ Widowed	⎕ Active ⎕ Disabled ⎕ Retired ⎕ Other (specify)

PATIENT INFORMATION

Is Claim for your dependent? ⎕ Yes ⎕ No	Patient's Name (First, Middle initial, Last Name)	Patient's Date of Birth

Full Time Student? ⎕ Yes ⎕ No If yes, where?	Patients Relationship to Employee ⎕ Self ⎕ Spouse ⎕ Child	Married? ⎕ Yes ⎕ No

Medicare Coverage Effective Date	Date Sickness began or injury occurred:	Did injury occur at work? ⎕ Yes ⎕ No Was sickness caused by work? ⎕ Yes ⎕ No
⎕ Hospital (Part A) only ⎕ Medicare (Part B) only ⎕ Both (A&B) ⎕ None		

Was the injury caused by an automobile accident? ⎕ Yes ⎕ No If Yes, specify city and state below	Doctor's Name	When did the patient first see the Doctor?

SPOUSE INFORMATION

Name	Date of Birth	Social Security Number	Employment Status ⎕ Active ⎕ Not Employed ⎕ Retired

Employer Name and Address

IF YOU OR YOUR FAMILY ARE COVERED UNDER ANOTHER FROUP HEALTH PLAN COMPLETE THE FOLLOWING SECTION

Covered Family Member ⎕ Self ⎕ Spouse ⎕ Child ⎕ Other: Specify Name & Relationship	Type of Coverage ⎕ Individual ⎕ Family	Policy Number	Insurance ID Number

Name of Insurance Company	Address	City	State	Zip Code

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE PLAN FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULANT INSURRANCE ACT, WHICH IS A CRIME

AUTHORIZATION FOR RELEASE OF INFORMATION: I/We authorize the release to PHPC and its agents of any evidence of information about me or my dependents that may pertain to this or any related claim. A copy of this authorization shall be as valid as the original (Patient's signature is required if patient is a legal adult.)

Member's Signature	**Date**	**Patient's Signature**	**Date**