Essential StaffCARE

Medical/Rx Claim Form

BCS pai

Claim Form Instructions

1. Make a copy of this form. 2. Completely fill out Sections 1-4 (Section 5 is optional). 3. Sign and date Section 6. 4. Remember to give your Social Security Number.
5. Attach itemized bills providing complete information on:
   • Doctor's name and address • Doctor's tax identification number • Patient's name • Diagnosis Code ICD-9 • Date of service • Charges/Cost of each treatment• Procedure Codes CPT-4 • Place of service code • **Note:** Itemized bills are not balance due statements or Explanation of Benefits.
6. If your medical provider sends your bill or claim to us, make sure an itemized bill is included. 7. Sign Section 5 if you want benefits paid to your medical provider.
8. If you have a Certificate of Creditable Health Coverage from your previous health insurance plan, please attach it to your completed Medical Claim Form and send it to the address at the bottom of this form. Keep a copy for your records.

Section 1: Employee Information

Employee's Name ______________________________ SSN: ____—____—____
Last First Middle

Telephone: (____) ____—______ Employer Name:__________ Group Number (obtain from ID card):__________

Address: ______________________________
Street City State ZIP

Section 2: Patient Information

Patient's Name: ______________________________
Last First Middle

SSN:____—____—____ Birth Date:____/____/____ Sex: ☐ Male ☐ Female

Relationship to employee: ☐ Self ☐ Spouse ☐ Daughter ☐ Son ☐ Other: (specify)__________

If the patient is your child and over 18, is he or she dependent upon you for support? ☐ Yes ☐ No Is he or she disabled? ☐ Yes ☐ No

Is he or she a full-time student? ☐ Yes ☐ No Name of School: __________
Submit documentation of school enrollment from Registrar office.

Section 3: Claim Information

Is the claim for an ☐ accident or ☐ illness Is treatment a result of occupational illness or injury? ☐ Yes ☐ No

When did the accident or illness occur?____/____/____

Please explain what you were treated for, and if it was an accident, provide details on how, when and where it happened. (Use the back of this form or attach a sheet of paper to this form if necessary.)______________________________

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Section 4: Prescription Drug Information

If you have more than two medications, please use the back of this form or attach an additional sheet of paper to this form.

1. Name of Medication__________ Condition being treated __________
2. Name of Medication__________ Condition being treated__________

Section 5: Assignment of Benefits

To be completed by employee. Do not sign if fees have already been paid.

I approve the payment of benefits to the doctor or other medical provider shown on the itemized bill (whose Tax Identification Number is included). I understand that I am financially responsible for all charges not covered by this approval.

Signature of Employee:______________________________ Date: __________

Section 6: Authorization

Instructions: The authorization should be completed and signed by the insured. If the insured is unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To all physicians, hospitals, medical service providers, pharmacists, employers, consumer reporting agencies, law enforcement agencies and any other agencies or organizations (including other insurance companies, Social Security Administration, Blue Cross Blue Shield, self-insured and prepaid health plans):

You are authorized to permit Planned Administrators, Inc. and its authorized representatives to view and obtain copy of ALL RECORDS including employment, law enforcement, tax, financial, insurance claim records, and medical records as to examination, history, diagnosis, treatment, and prognosis with respect to any physical or mental condition including information relating to mental illness, drug or alcohol treatment, HIV (AIDS virus) and disease of:______________________________.
Print Name of Insured

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

______________________________ __________ __________
Signed Date Relationship to insured if signed by other than insured

(If signed by other than the Insured, please print name and address and include guardianship papers or other evidence of legal representation.)

______________________________ ______________________________
Name Address

Send Medical Claims to: Essential StaffCARE, Attn: Claims, PO Box 6702, Columbia, SC 29260-6702

Please note: Incomplete forms and the absence of itemized bills may delay the processing of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

The laws of some states require us to furnish you with the following notices:

WARNING. Any person who knowingly:

Alaska: and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona and Arkansas: presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California, Louisiana, New Mexico and Texas: presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.)

Delaware: and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho and Indiana: and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information (for Idaho) is guilty of and (for Indiana) commits a felony.

Kentucky, New York and Pennsylvania: and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, **specific to PA:** subjects such person to criminal and civil penalties and **specific to NY:** shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

New Jersey: files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: with intent to defraud or knowing that he 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.

Oklahoma: and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

WARNING:

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia, Tennessee and Virginia: It Is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company, (or **specific to DC:** any other person.) Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Hawaii: Presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.