



## HOW TO FILE A MEDICAL CLAIM

**Claim payment may be delayed if information is incomplete or missing.**

Please note that HCFA and UB claim forms are available upon request from your provider.

\_\_\_\_\_ **Part One – Attach itemized bills.**

Itemized bills are not balance due statements or Explanation of Benefits.

**Checklist to make sure all information required has been enclosed:**

- \_\_\_\_\_ **Doctor's name and address**
- \_\_\_\_\_ **Doctor's tax ID number**
- \_\_\_\_\_ **Patient's name**
- \_\_\_\_\_ **Diagnosis Code(s) ICD-9**
- \_\_\_\_\_ **Date of service**
- \_\_\_\_\_ **Charges/Cost of each treatment**
- \_\_\_\_\_ **Procedure Code(s) CPT-4**
- \_\_\_\_\_ **Place of service code**

\_\_\_\_\_ **Part Two (Page 2) – to be complete signed and dated.**

To be completed by the Employee. Please note that employee signature, social security number, and authorization are required.

\_\_\_\_\_ **Part Three – Keep a copy for your records.**

Mail your Medical claim form and itemized bills to:

**PAI, P.O. Box 6702 Columbia, South Carolina 29260**



## Medical Claim Form

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.

### Section 1: Employee Information

Employee's Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State ZIP

Phone Number: \_\_\_\_\_ Employer Name: \_\_\_\_\_ Group Number(obtain from ID card): \_\_\_\_\_

### 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: \_\_\_\_\_

### 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? \_\_\_\_\_ First date consulted for the diagnosis? \_\_\_\_\_

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.) \_\_\_\_\_

### Section 4: 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., its Third Party Administrators, 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.

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

Legal Guardian Name \_\_\_\_\_ Relationship to insured if signed by other than insured \_\_\_\_\_ Address \_\_\_\_\_





Send Medical Claims to: PAI, Attn: Claims, P.O. Box 6702, Columbia, SC 29260

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

#### Fraud Statement

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.