

Benefit Options

Choice. Value. Health.

MEDICAL CLAIM FORM

AZ Benefit Options - UMR
Group #: 3J

MAIL CLAIM TO:
ARIZONA FOUNDATION FOR MEDICAL CARE
P.O. BOX 2909
PHOENIX AZ 85062-2909
CUSTOMER SERVICE # 888-999-1459

INSTRUCTIONS FOR EMPLOYEE OR RETIREE		FULLY COMPLETE PARTS 1 THRU 4 AS APPLICABLE. WHEN HOSPITAL AND/OR DOCTOR HAVE COMPLETED THE BOTTOM PORTION OF FORM, SUBMIT CLAIM TO THE ABOVE ADDRESS. (A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH PERSON.)																
1	COMPLETE FOR ALL CLAIMS	EMPLOYEE OR RETIREE'S NAME (FIRST/MIDDLE/LAST)					MEMBER ID #		HOME TELEPHONE #									
		EMPLOYEE OR RETIREE'S HOME ADDRESS (NO., STREET, CITY, STATE, ZIP CODE)							WORK TELEPHONE #									
		ARE YOU, YOUR SPOUSE, OR YOUR DEPENDENT CHILDREN ENTITLED TO BENEFITS FROM ANY OTHER KIND OF GROUP HEALTH INSURANCE OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO																
		IF YES, NAME AND ADDRESS OF OTHER INSURANCE COMPANY AND/OR ORGANIZATION WHERE CLAIMS ARE SUBMITTED.					POLICY #											
INSURANCE CO.: _____					SOCIAL SECURITY #			<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; border: 1px solid black; height: 20px;"></td> <td style="width:10%; border: 1px solid black; height: 20px;"></td> <td style="width:10%; border: 1px solid black; height: 20px;"></td> <td style="width:10%; border: 1px solid black; height: 20px;"></td> <td style="width:10%; border: 1px solid black; height: 20px;"></td> <td style="width:10%; border: 1px solid black; height: 20px;"></td> <td style="width:10%; border: 1px solid black; height: 20px;"></td> <td style="width:10%; border: 1px solid black; height: 20px;"></td> <td style="width:10%; border: 1px solid black; height: 20px;"></td> <td style="width:10%; border: 1px solid black; height: 20px;"></td> </tr> </table>										
ADDRESS: _____																		
2	MUST BE COMPLETED FOR AN ACCIDENT OR INJURY CLAIM	DATE OF ACCIDENT OR ILLNESS		HOUR		IS THE SICKNESS OR INJURY DUE TO:												
		MO _____ DAY _____ YR _____		A.M.		OCCUPATIONAL CAUSES? <input type="checkbox"/> YES <input type="checkbox"/> NO												
				P.M.		ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO												
WILL THE PATIENT FILE A CLAIM AGAINST A 3 RD PARTY LIABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO				IF ACCIDENT: MOTOR VEHICLE? <input type="checkbox"/>														
				OTHER ACCIDENT? <input type="checkbox"/> _____														
GIVE A BRIEF DESCRIPTION OF THE ACCIDENT AND PLACE WHERE THE ACCIDENT OCCURRED (INCLUDING CITY AND STATE).																		
3	COMPLETE ONLY FOR A DEPENDENT CLAIM	NAME OF PATIENT			RELATIONSHIP TO YOU			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH									
		IS THIS PATIENT EMPLOYED? (IF "YES," NAME AND ADDRESS OF HER OR HIS EMPLOYER) <input type="checkbox"/> YES <input type="checkbox"/> NO																
4	YOU MUST DATE AND SIGN	I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATIVE TO THIS CLAIM TO AZ BENEFIT OPTIONS - UMR AND DIRECT THAT BENEFITS BE MADE PAYABLE TO: <input type="checkbox"/> PROVIDER <input type="checkbox"/> MYSELF					SIGNED (EMPLOYEE)		DATE									
		I CERTIFY THAT THE INFORMATION I FURNISH IN SUPPORT OF THIS CLAIM IS TRUE AND CORRECT. IF IS UNLAWFUL TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.					SIGNED (DEPENDENT PATIENT, AGE 18 & OVER)		DATE									
MEDICAL/SURGICAL PHYSICIAN'S STATEMENT																		
Date of service To From		Place of service *	# of visits	Procedure code	Fully describe procedures, medical services, or supplies furnished for each date given. (Explain unusual services or circumstances)			Diagnosis code	Charges									
* Place of Service: Office, Hospital, Other					PATIENT'S ACCOUNT #		TOTAL CHARGES											
PHYSICIAN'S NAME (PRINT)					DEGREE		AMOUNT PAID											
							BALANCE DUE											
STREET ADDRESS			CITY OR TOWN		STATE OR PROVINCE			ZIP CODE										
PHYSICIAN'S SIGNATURE				DATE SIGNED		TELEPHONE #		EMPLOYER ID#										
								MUST BE FURNISHED UNDER AUTHORITY OF LAW.										