CONSOCIATE HEALTH SM

INSURANCE CLAIM FORM

1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER ☐ (Medicare A) ☐ (Medicare B) ☐ (Sponsors SSN) ☐ (Memb. ID) ☐ SSN) ☐ (SSN) ☐ (ID)		1b. INSURED'S I.D. NUMBER (For Program in item 1)
2. PATIENTS NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SEX MM DO YY M ☐ F ☐ / /	4. INSURED'S NAME (Last Name, First Name, MI)
5. PATIENTS ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employee ☐ Full-Time Student ☐ Part Time Student ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Inc. Area Code)
9. OTHER INSUREDS NAME (Last Name, First Name, MI)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH SEX MM DO YY M ☐ F ☐ / /
b. OTHER INSURED'S DATE OF BIRTH SEX MM DO YY M ☐ F ☐ / /	b. AUTO ACCIDENT? ☐ YES ☐ NO	b. EMPLOYERS NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10 a. IF YES, PLEASE PROVIDE DATE & DETAILS.	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes, return to and complete Item 9 a-d*
12. PATIENTS OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of my medical or other information necessary to process this claim. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to be sent to the physician or supplier for services as attached. SIGNED _____ DATE: _____

Please attach itemized bill for insurance purposes and mail to:

Consociate Health
P.O. Box 1068
Decatur, IL 62525

Consociate Health Customer Service
Phone: 800-798-2422 Fax: 217-423-4575
customerservice@consociate.com