

STAPLE ATTACHMENTS

**HEALTH CLAIM FORM
FOR PROFESSIONAL
SERVICES ONLY**



MAIL TO:

**DocFirst
P.O. Box 17098
Owings Mills, MD 21117-7098**

FOR EMPLOYEES OF:
NEXTEL COMMUNICATIONS, INC.

DocFirst Customer Care Center: 1-888-883-4458

INSTRUCTIONS: THIS SIDE OF THE FORM MUST BE COMPLETED IN FULL. Attach this form to itemized bills for all expenses being claimed. The bills must show: Patient's Name, Type of Service, Date(s) of Service(s), and the Total Charge. If you are submitting a surgical bill or if the bills are for a major illness, accident, or hospitalization, the reverse side of this form must be completed by the attending physician. **AVOID DELAY-ANSWER ALL QUESTIONS.**

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

Employee Name: (First name, middle initial, last name)	Social Security #	Marital Status: <input type="checkbox"/> Single, Divorced, Widowed or Legally Separated <input type="checkbox"/> Married
Street Address: (street, city, state, zip code) Complete only if new address		Date of Birth: Month, Day, Year
		Telephone No.: ()

DEPENDENT'S INFORMATION: (complete only if patient is dependent)

Name of Dependent:	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
If claim is for dependent child 19 or older, is child enrolled as full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of School:	Date of Birth: Month, Day, Year
AT TIME CHARGES WERE INCURRED: (If answer is yes, give employer's name and address)		
Was spouse employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Employer's Name:	
If claim was for child, was child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Address:	

COMPLETE FOR ALL PATIENTS:

Nature of Injury or Illness		
When were you first treated for this condition? (month, day, year)	Name and address of physician who first treated you:	
Is patient also covered for benefits by: a. Other Group Health Insurance of any kind including Blue Cross and Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Group prepayment arrangement providing for medical care and treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? <input type="checkbox"/> Yes <input type="checkbox"/> No d. No fault automobile insurance as a result of injuries sustained in an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was illness or injury due in any way: a. To the patient's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No b. To an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Any other type of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If any of above are answered "YES" give details under "Accident."</i>
Remarks:		
ACCIDENT Date: _____ (Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.)	Place of accident: <input type="checkbox"/> Work <input type="checkbox"/> Other	Specify:
How did accident happen?	Name and address where accident occurred:	

I authorize payment of the attached medical bills to the providers of care YES NO

I certify that the preceding statements and answers and the attached bills and/or statements are true and complete to the best of my knowledge. I authorize the release of information and medical records to DocFirst containing the diagnosis and treatment provided to me or my eligible dependent. I understand this information will be held confidential.

Employee's Signature _____ Date _____

Spouse's Signature (if patient) _____ Date _____

PLEASE PRINT OR TYPE

Patient's Name	Patient's Birth Date	Social Security Number
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To Physician: Elective hospitalizations are subject to certification prior to admission.

VERIFICATION OF SERVICES

In order to process your bill for services as part of your patient's claim for health care expense reimbursement, we require the following data. *Your cooperation is appreciated.*

PHYSICIAN OR SUPPLIER OF INFORMATION

Date of: ILLNESS (first symptom,) or INJURY (Accident), or PREGNANCY (LMP)	Date patient first consulted you for this condition	Has patient ever had same or similar symptoms? <input type="checkbox"/> YES <input type="checkbox"/> NO
Provider of Care (please check) <input type="checkbox"/> Attending <input type="checkbox"/> Surgeon <input type="checkbox"/> Consulting		If other than attending, give name of referring physician
Name & address of facility where services rendered (if other than home or office)		For services related to hospitalization, give hospitalization dates ADMITTED _____ DISCHARGED _____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM E BY LINE)

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

A						B	C	D		E	F	G	H	I	J	K
DATE(S) OF SERVICE						Place of	Type of	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE	\$ CHARGES	DAYS OR	EPSDT Family	EMG	COB	RESERVED FOR LOCAL USE
MM	From DD	YY	To MM	DD	YY											

Signature of Provider Date _____ Signed _____	Total Charge	Amount Paid	Balance Due
Provider I.D. number	License number		
Your patient's account number	Provider's name, address, zip code, and telephone number		

All providers must be licensed according to the requirements of their jurisdiction. Patients of Clinical Social Workers must be referred by a physician. If therapy was rendered by a Clinical Social Worker, please provide the name and address of the referring physician in the space provided below.

Name: _____ Address: _____

- *Place of service codes**
- | | | | |
|----------------------------|-----------------------------|----------------------------------|---|
| 1—(IH) Inpatient Hospital | 4—(H) Patient's Home | 7—(NH) Nursing Home | O—(OL) Other Location |
| 2—(OH) Outpatient Hospital | 5—(PSY) Daycare Facility | 8—(SNF) Skilled Nursing Facility | A—(IL) Independent Laboratory |
| 3—(O) Doctor's Office | 6—(PSY) Night Care Facility | 9—(AMB) Ambulance | B—(OMF) Other Medical Surgical Facility |