



Statement of Claim
To Be Completed By The Employee

1016 Collier Center Way, Suite 200
Naples, Florida 34110
239-403-7884 • Fax 239-403-9028 • 800-720-1774

Employer Name _____

Group No. _____

Submit only itemized bills. Drug receipts should always include a prescription number.
If you submit bills for covered services not reported on an "Attending Physician's Statement," each bill must describe name of patient, diagnosis, nature of services or supplies furnished, as well as the date and amount charged for each.

Please print full name		Employment status: <input type="checkbox"/> Active <input type="checkbox"/> Retired		Social Security number [][]-[][]-[][][][]	
Home address		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally separated		First name of spouse	
City State ZIP Code		Name and address of company where spouse is employed		Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of birth Telephone number		Spouse's Social Security number [][]-[][]-[][][][]			
Patient's name		Date of birth		Marital status if other than spouse	
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally separated	
		<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child			
Is patient eligible for Medicare as a disabled person or due to renal dialysis or kidney transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, effective date of Medicare is _____					
If patient is a child 19 or over: name and address of school				Date of enrollment	
				<input type="checkbox"/> Full time <input type="checkbox"/> Part time	
If bills are being submitted for nursing services or physiotherapy, enclose a statement from your physician showing that he ordered all such services. Also, were any such services rendered by a close relative, that is, your spouse or child, brother, sister or parent of either yourself or your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date accident occurred or sickness began?		Description of injury or sickness. If accident, date, how and where it occurred.			
Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No - If "Yes," explain _____					
IS PATIENT COVERED BY ANOTHER PLAN					
1. Any other Group Plan, Welfare Plan or other arrangement of coverage for individuals in a group?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Blue Cross, Blue Shield or any other prepayment arrangement maintained on a group basis?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Any other coverage provided by an employer or any federal, state, or other governmental agency?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. No-fault automobile plan as a result of injuries sustained in an automobile accident?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes" please furnish name and address of employer, insurance company or governmental agency, type of coverage, and policy number.					
THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE ANY EMPLOYER, INSURANCE COMPANY, MEDICAL PREPAYMENT PLAN, SERVICE ORGANIZATION, PHYSICIAN, PRACTITIONER OR OTHER PERSON; ANY HOSPITAL, INCLUDING THE VETERANS ADMINISTRATION, OR OTHER INSTITUTION TO RELEASE TO OR OBTAIN FROM SIP, ANY MEDICAL OR BENEFIT PAYMENT INFORMATION THAT MAY BE REQUIRED TO ESTABLISH THE VALIDITY OF THIS CLAIM, AND FURTHER AUTHORIZE SAID COMPANY, PERSON OR ORGANIZATION, TO DISCLOSE ANY PERSONAL OR CLAIM INFORMATION REQUIRED FOR MEDICAL CASE STUDY OR REVIEW. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.					
Spouse's signature and date			Employee's signature and date		
_____			_____		
Assignment of Benefits I hereby authorize payment directly to the physician, hospital, or supplier who provided services for which benefits are payable, but not exceed the usual and prevailing charge.					
Employee's signature					Date
_____					_____

