

**HEWITT, COLEMAN & ASSOCIATES, INC.**  
**Statement of Claim for Group Medical Benefits**

**Mail to:** Post Office Box 6708  
 Greenville, SC 29606  
**Telephone:** 1-888-298-6828  
**Fax:** 1-864-255-4864

**HOW TO FILE A CLAIM:** Complete this side of form and top portion of reverse side for assignment of benefits. Have the attending physician complete his portion of reverse side if you do not have the billing.

<b>NAME AND ADDRESS OF EMPLOYER</b>	   	Group No. _____
<b>ABOUT THE EMPLOYEE</b>	Name _____ Soc. Sec. No. _____ Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired Address _____ _____	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated Date of Birth ____/____/____
<b>ABOUT THE EMPLOYEE'S SPOUSE</b>	Name of Spouse _____ Birthdate ____/____/____ Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse's Employment Status? <input type="checkbox"/> Active <input type="checkbox"/> Retired Does Spouse's Employer Provide Group Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Your Spouse Covered By That Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name & Address of Spouse's Employer _____ _____
<b>ABOUT THE PATIENT</b>	This Claim is For: <input type="checkbox"/> Myself *If disabled, 1st day not worked ____/____/____ Expected Return ____/____/____ <input type="checkbox"/> My Spouse _____ Date of Birth ____/____/____ <input type="checkbox"/> My Child Name _____ Date of Birth ____/____/____	Is Child Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer or School Name _____ City _____ State _____
<b>ABOUT THE CLAIM</b>	This Claim is Due To: (complete question 1, and either 2A or 2B) 1. Is this condition related to your job? <input type="checkbox"/> Yes <input type="checkbox"/> No 2A. AN ACCIDENT Nature of Injury? _____ _____ How did it Happen? _____ _____ Where _____ When ____/____/____ First Physician Consult/Visit? ____/____/____	
<b>ABOUT OTHER INSURANCE</b>	Is the Patient Covered by One or More of the Following? Any other group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Any federal, state or other government plan, or union welfare plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Any medical plan sponsored by a school or college? <input type="checkbox"/> Yes <input type="checkbox"/> No Any auto insurance if an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If "Yes" to any of the Above, Name & Address of the Other Insurance Company? _____ _____	Name of Insured _____ Policy # or Certificate _____ _____ Name & Address of Employer, Group or School Providing Plan _____ _____

Certification & Authorization (to be signed by the patient {or parent if patient is minor} and the certificate holder)  
 I hereby certify that the above answers and statements hereon and attached are to the best of my belief accurate. I hereby authorize any hospital, physician or other insurance company to furnish Hewitt, Coleman & Associates, Inc. or its representative or permit said company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records or other company records. A photocopy of this authorization shall be considered as valid as the original.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient's Signature \_\_\_\_\_ Certificate Holder's Signature \_\_\_\_\_

**\*\*\*INCOMPLETE ANSWERS MAY DELAY PROCESSING**

<b>ASSIGNMENT OF BENEFITS</b>	
I hereby direct that all hospital benefits due me be paid directly to (name and address of hospital) _____ _____ _____ Signature of Insured Person _____	I hereby direct that all surgical or medical benefits due me be paid directly to (name and address of physician) _____ _____ _____ Signature of Insured Person _____
Please reimburse me for benefits due and I understand I am financially responsible for any expenses due the provider of service.  Signature of Insured Person _____	Please reimburse me for benefits due and I understand I am financially responsible for any expenses due the provider of service.  Signature of Insured Person _____

**PHYSICIAN OR SUPPLIER INFORMATION**

14. Date of Illness (first symptom) or injury (accident) or pregnancy (LMP): \_\_\_/\_\_\_/\_\_\_      15. Date first consulted you for this condition: \_\_\_/\_\_\_/\_\_\_      16. Has patient ever had same or similar symptoms?  Yes  No

17. Date patient able to return to work? \_\_\_/\_\_\_/\_\_\_      18. Date of Total Disability? From \_\_\_/\_\_\_/\_\_\_ Through \_\_\_/\_\_\_/\_\_\_      19. Date of Partial Disability? From \_\_\_/\_\_\_/\_\_\_ Through \_\_\_/\_\_\_/\_\_\_

20. Name of Referring Physician? \_\_\_\_\_      21. For services related to hospitalization, give hospitalization dates? Admitted \_\_\_/\_\_\_/\_\_\_ Discharged \_\_\_/\_\_\_/\_\_\_

22. Name and Address of Facility where services rendered (if other than office)? \_\_\_\_\_      23. Was laboratory work performed outside your office?  Yes  No  
Charges? \_\_\_\_\_

24. Diagnosis or nature of illness or injury. Relate diagnosis in column D by reference number 1, 2, 3, etc. or DX code

1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_  
 4 \_\_\_\_\_

Date of Service	Place of Service	Procedure Code	Fully describe procedures, medical services or supplies furnished for each given date	Diagnostic Code	Charges	Comments

25. Signature of Physician or Supplier Signed _____ Date ___/___/___	26. Accept assignment (government claims only) <input type="checkbox"/> Yes <input type="checkbox"/> No	27. Total Charge: _____	28. Amt. Pd. _____	29. Bal. Due _____
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30. Your Social Security # or Employers ID #: _____	31. Patient's account #: _____	32. Physician's or Supplier's name, address, zip code & telephone number. _____ _____
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- \*\*Must be furnished under authority of law.**
- Place of Service Codes
- |                           |                            |                                 |   |
|---------------------------|----------------------------|---------------------------------|---|
| 1-(IH)Inpatient Hospital  | 4-(H)Patient's Home        | 7-(NH)Nursing Home              | 10-(OL)Other Locations                  |
| 2-(OH)Outpatient Hospital | 5-(PSY)Day Care Facility   | 8-(SNF)Skilled Nursing Facility | 11-(IL)Independent Labs                 |
| 3-(O)Doctor's Office      | 6-(PSY)Night Care Facility | 9-(AM)Ambulance                 | 12-(OMS)Other Medical/Surgical Facility |

\*\*For surgical procedure code, please use California Relative Value Study or equivalent: for Diagnosis Code ICDA revision 8.

Approved by AMA Council on Medical Service 6-74