Insurance Company of the State of Pennsylvania

Al Grippo
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685 Third Avenue, 12th Floor
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clm dpt: (212) 770-2806

PROOF OF LOSS

NAME OF GROUP: Brookhaven Science Associates

POLICY NUMBER: GLB 9028764

ACCIDENT AND SICKNESS CLAIM FORM

INSTRUCTIONS:
1.) This form is to be used when filing a claim for reimbursement of Medical Expenses.
2.) Section A must be completed by the Insured in full.
3.) One of the following must be provided:
A.) Section B fully completed by the Attending Physician, or
B.) Fully itemized bills including: Claimant's Name, Nature of Illness/Injury, Description and Charge for each service provided.
4.) This form must be signed and dated in all applicable sections.
5.) This form and all attached bills must be submitted to the address indicated above.
6.) Indicate if this medical bill is to be paid to the health care provider or to the Insured Person (circle one).
7.) List family members covered (on the last page) if the Insured Person has chosen the Family Plan.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A // Family Plan ( ) or Individual Plan ( ) // First Claim Submitted? yes ( ) / no ( ) // Certificate Number _____ (If applicable)

Coverage Effective Date ___/___/___ Coverage Termination Date: ___/___/___

1.) Name of Insured: _____ (PLEASE PRINT) Date of Birth: ___/___/___ Sex: ☐ Male ☐ Female

2.) Name of Claimant: _____ (PLEASE PRINT) Claimant's Date of Birth: ___/___/___ Sex: ☐ Male ☐ Female

3.) Current Residence Address: _____

Date of arrival in Country.: ___/___/___ Daytime phone number: ( ) _____

4.) Permanent Address (In Home Country): _____

Date scheduled to return to Home Country: ___/___/___

5.) If Accident, provide details, i.e., how when and where accident occurred: _____

6.) If Sickness, advise when and where symptoms first occurred: _____

7.) Name and address of Consulting Physicians : _____

8.) Have you ever been treated for this illness before? _____

If yes, provide name and address of treating Physician(s) and date(s) first consulted: _____

9.) Provide Name and Address of your Regular Physician in your Home Country: _____

10.) Please advise names of any prescription medications you are presently taking: _____

11.) Indicate other Health Insurance coverage, include name, address, policy number and certificate number of Insurer: _____

AUTHORIZATION

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

SIGNATURE OF CLAIMANT OR PARENT, IF CLAIMANT IS A MINOR _____ DATE _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE _____ DATE _____

Section B

HEALTH INSURANCE CLAIM FORM

CLAIMANT INFORMATION

1. MEDICARE ☐ (Medicare #) ☐ (ID)
MEDICAID ☐ (Medicaid #)
CHAMPUS ☐ (Sponsor's SSN)
CHAMPVA ☐ (VA File #)
GROUP HEALTH PLAN ☐ (SSN or ID)
FECA BLK LUNG ☐ (SSN)
OTHER

1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (First Name, Middle Initial, Last Name)

3. PATIENT'S DATE OF BIRTH MM / DD / YY
SEX M ☐ F ☐

4. INSURED'S NAME (First Name, Middle Initial, Last Name)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐ (SPECIFY)

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS
Single ☐ Married ☐ Other ☐
Employed ☐ Full Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE NO. ( )

ZIP CODE | TELEPHONE NO. ( )

9. OTHER INSURED'S NAME

A. OTHER INSURED'S POLICY OR GROUP NUMBER

B. OTHER INSURED'S DATE OF BIRTH MM / DD / YY
SEX M ☐ F ☐

C. EMPLOYER'S NAME OR SCHOOL NAME

D. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO.
A. PATIENT'S EMPLOYMENT? YES ☐ NO ☐
B. AN AUTO ACCIDENT? YES ☐ NO ☐
C. OTHER ACCIDENT? YES ☐ NO ☐
D. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

3. PATIENT'S DATE OF BIRTH MM / DD / YY
SEX M ☐ F ☐

B. EMPLOYER'S NAME OR SCHOOL NAME

C. INSURANCE PLAN NAME OR PROGRAM NAME

D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to 8 complete item 9 A-D

12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE.
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
Signature _____ Date _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.
I authorize payment of medical benefits to undersigned physician or supplier for service described below.
Signature _____ Date _____

14. DATE OF CURRENT: MM DD YY / / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE: MM / DD / YY / /

16. Dates Patient Unable To Work in Current Occupation MM / DD / YY FROM: / / TO: / /

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. Hospitalization Dates Related to Current Services MM / DD / YY FROM: / / TO / /

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
1 _____ 3 _____
2 _____ 4 _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements apply to this bill and are made a part thereof.)
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE #
PIN# GRP#

PLACE OF SERVICE CODES
1-(H) - INPATIENT HOSPITAL
2-(OH) - OUTPATIENT HOSPITAL
3-(O) - DOCTOR'S OFFICE
4-(H)-PATIENT'S HOME
5- -DAYCARE FACILITY (PSY)
6- -NIGHT CARE FACILITY(PSY)
7-(NH) NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9- -AMBULANCE
0-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B- -OTHER

List of family members covered if the Insured Person is covered under the Family Plan: