

SAN DIEGO COUNTY SCHOOLS FRINGE BENEFITS CONSORTIUM

- 1. Complete this form
- 2. Attach all bills
- 3. Mail to



MEDICAL CLAIM
 6401 LINDA VISTA ROAD #505
 SAN DIEGO, CALIFORNIA 92111-7399
 (858) 292-3542 or Toll Free (888) 233-7915
 FAX (858) 569-5086

MAIL CLAIM TO:
 P.O. Box 729
 Buckeys Town, MD 21717

FILL OUT A SEPARATE FORM FOR EACH MEMBER SUBMITTING BILLS FOR COVERED SEI
PLEASE PRINT OR TYPE. SEE REVERSE SIDE FOR "HOW TO USE THIS FORM."

PART I: Must be Completed by Employee

1. NAME OF EMPLOYER		DISTRICT		2. GROUP NO. J P A K _ _ _ _	
3. EMPLOYEE NAME LAST FIRST MI		4. SOCIAL SECURITY NO.		5. MARITAL STATUS	
6. MAILING ADDRESS		7. EMPLOYEE BIRTHDATE / /		8. TELEPHONE NUMBER	
9. CITY		STATE		ZIP	
10. PATIENT NAME (IF OTHER THAN EMPLOYEE)		11. PATIENT BIRTHDATE / /		12. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/>	
14. DATE OF INJURY OR START OF ILLNESS / /		15. NATURE OF ILLNESS, OR IF INJURED, HOW/WHERE DID INJURY OCCUR AND FIRST DATE OF TREATMENT		13. IF CHILD, FULL TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
				THIRD PARTY INVOLVED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16. ARE ANY OF THE ILLNESSES OR ACCIDENTS FOR WHICH CLAIM IS BEING MADE RELATED TO EMPLOYMENT?				<input type="checkbox"/> YES <input type="checkbox"/> NO	
17. NAME AND ADDRESS OF PATIENT'S EMPLOYER				18. SOC. SEC. #	
19. ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANY OTHER GROUP INSURANCE HEALTH MAINTENANCE ORGANIZATION, OR GOVERNMENT PLAN (E.G. MEDICARE, MEDI-CAL, MEDICAID)? <input type="checkbox"/> YES <input type="checkbox"/> NO				20. POLICY # EFFECTIVE DATE ___/___/___	
21. NAME & ADDRESS OF INSURANCE CARRIER OR PLAN				EFFECTIVE DATE & PHONE #	
22. PATIENT OR AUTHORIZED PERSON'S SIGNATURE I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I CERTIFY THE ABOVE INFORMATION IS CORRECT. (SEE ITEM #6, OVER) X DATE		23. EMPLOYEE OR AUTHORIZED PERSON I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. X DATE		24. EMPLOYEE OR AUTHORIZED PERSON I CERTIFY THAT THIS CLAIM HAS BEEN PAID IN FULL. MAKE PAYMENT OF MEDICAL BENEFITS TO THE EMPLOYEE. X DATE	

PART II: To be Completed by Physician (or attach itemization)

25. PATIENT'S NAME		26. DATE OF BIRTH		27. DOES PATIENT HAVE OTHER INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IDENTIFY:	
28. DATE OF ILLNESS (FIRST SYMPTOM) ACCIDENT OR PREGNANCY (LMP):		29. DATE FIRST CONSULTED REFERRING PHYSICIAN:		30. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE:	
31. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE					
1.					
2.					
3.					
4.					
WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES:					
A DATE OF SERVICE	B PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE* (IDENTIFY)* (Explain unusual services or circumstances)		D DIAGNOSIS CODE	E CHARGES
PHYSICIAN'S NAME		DEGREE		SIGNATURE	
ADDRESS		CITY		ZIP CODE	
				TELEPHONE	
				EMPLOYER ID #	

*PLACE OF SERVICE CODES

- | | | | |
|--------------------------------|---------------------------------|--------------------------------------|-------------------------------------|
| 1 - (IH) = INPATIENT HOSPITAL | 4 - (H) = PATIENT'S HOME | 7 - (NH) = NURSING HOME | O - (OL) = OTHER LOCATIONS |
| 2 - (OH) = OUTPATIENT HOSPITAL | 5 - (PSY) = DAY CARE FACILITY | 8 - (SNF) = SKILLED NURSING FACILITY | A - (IL) = INDEPENDENT LAB |
| 3 - (O) = DOCTOR'S OFFICE | 6 - (PSY) = NIGHT CARE FACILITY | 9 - AMBULANCE | B - OTHER MEDICAL/SURGICAL FACILITY |