Claim Form

TO BE COMPLETED BY CARDHOLDER/EMPLOYEE *PLEASE PRINT*

1	Group #	Employer		Policy holder/Subscriber ID
2	If applicable, apply unreimbursed expenses to Flex Account ____ Yes ____ No		Employee Status ____ Active ____ Retired ____ COBRA ____ Terminated	
3	Name of Cardholder/Employee	____ Married ____ Single	____ Male ____ Female Birthdate:	Phone Number
4	Address of Cardholder/Employee Number & Street		City	State Zip

5	For dependent claims, complete lines 5, 6, 7	Name of Dependent	____ Married ____ Single	____ Male ____ Female Birthdate:	Relationship
6		Employer (if any) of Dependent	Address of Employer		
7		School where Dependent is enrolled	Expected graduation date		

8	Are you or any of your family members covered under another group health plan or Medicare? ____ Yes ____ No	If yes:	(a) Insurance Co: (b) Employer: (c) Policy # or ID #:

9	Is claim based on accident/injury? ____ Yes ____ No If Yes, date of accident/injury:	Did accident/injury happen while working? ____ Yes ____ No	Auto Accident/Injury? ____ Yes ____ No
10	If so, advise how, when, where, accident/injury occurred:		If so, is legal counsel being sought? ____ Yes ____ No

ASSIGNMENT: I hereby authorize payment directly to the hospital, physician or dentist herein named of the group benefits payable to me. I understand I am financially responsible for charges not covered by this assignment.

_____

Cardholder/Employee Signature Date signed

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize NOVA HEALTHCARE ADMINISTRATORS, INC. or its authorized representatives, to obtain any information which may be necessary to determine benefits payable under the benefit plan administered by NOVA HEALTHCARE ADMINISTRATORS, INC. a photocopy of this authorization will be valid.

_____

Patient's Signature Date signed
(or parent if the patient is a minor)

COMPLETE ALL CLAIMS: I hereby certify that the above statements are complete and accurate to the best of my knowledge. I also agree to reimburse the Plan sponsor or its representatives to the extent of any overpayment which is in excess of the amounts payable under the group plan:

_____

Cardholder/Employee Signature Date signed

Please complete this form and be sure to include the following items:

- Itemized bill
- Patient name
- Date of services
- Diagnosis
- Procedure code (CPT)
- Provider's Tax ID number