



## OTHER INSURANCE COVERAGE INFORMATION

(If You Have An Explanation of Benefits, Please Attach). If patient is covered by another insurance plan, please complete the following:

INSURED'S NAME ON OTHER INSURANCE ID CARD	OTHER INSURANCE COMPANY'S NAME																				
OTHER INSURANCE COMPANY POLICY NUMBER	STREET																				
	CITY STATE ZIPCODE																				
IF SERVICE WAS A RESULT OF ACCIDENT, SHADE CIRCLE BELOW:  <input type="radio"/> AUTOMOBILE ACCIDENT  <input type="radio"/> WORK-RELATED ACCIDENT  <input type="radio"/> OTHER: _____	DATE OF ACCIDENT <table border="1"><tr><td> </td><td> </td><td>/</td><td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>MM</td><td></td><td></td><td>DD</td><td></td><td></td><td>YYYY</td><td></td><td></td><td></td></tr></table> DISABILITY DATES _____ THRU _____			/			/					MM			DD			YYYY			
		/			/																
MM			DD			YYYY															

## DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

--

## POLICY HOLDER PHONE NUMBER

Populate the best phone number to contact if we have a question about your claim(s).

	-		-	
--	---	--	---	--

## CERTIFICATION

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, the Plan may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. The signer hereby authorizes any insurer, employer, organization or health care service provider to release to the plan all information relating to past, present and future health care examinations or treatments received by each person covered by this claim/application. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient name.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REMEMBER TO ATTACH AN ITEMIZED STATEMENT OF SERVICES PERFORMED**