MEDICAL CLAIM

TYPE OR PRINT

INFORMATION WE NEED FROM YOU

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. EMPLOYEE'S NAME *(First name, middle initial, last name)*

4. PATIENT'S ADDRESS *(If different from employee)*

CITY STATE ZIP PHONE NO.

5. PATIENT'S SEX ☐ ☐ MALE FEMALE

MARITAL STATUS ☐ ☐ MARRIED SINGLE

6. EMPLOYEE ADDRESS IS THIS A NEW ADDRESS? ☐ YES ☐ NO

CITY STATE ZIP

7. PATIENT'S RELATIONSHIP TO INSURED

SELF SPOUSE CHILD OTHER

8. EMPLOYEE'S SOC. SEC. NO.

FULL-TIME STUDENT? ☐ YES ☐ NO IF YES, WHERE?

9. EMPLOYEE'S EMPLOYER

BROWARD HEALTH

10. EMPLOYEE'S DATE OF BIRTH

11. ☐ ACTIVE ☐ RETIRED
EFF. DATE OF RETIREMENT

12. ANY **OTHER** MEDICAL BENEFITS FOR EMPLOYEE, SPOUSE OR PATIENT? (CHECK ONE OF FOLLOWING) ☐ YES ☐ NO

WHO? ☐ SELF ☐ SPOUSE ☐ DEPENDENT. IF DEPENDENT OR SPOUSE FULL NAME _____ DATE OF BIRTH _____

COVERAGE PROVIDED THROUGH ☐ BLUE CROSS/BLUE SHIELD ☐ MEDICARE OR CHAMPUS ☐ HEALTH MAINTENANCE ORGANIZATION (HMO)
☐ EMPLOYER SPONSORED PLAN ☐ COMMERCIAL INSURANCE COMPANY ☐ MEDICAID ☐ OTHER

GIVE NAME AND ADDRESS OF OTHER COVERAGE ABOVE _____

13. ARE OTHER FAMILY MEMBERS EMPLOYED? ☐ YES ☐ NO
EMPLOYEE NAME SOC. SEC. NO.
IF YES

14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.

15. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT?
YES ☐ ☐ NO
B. AN ACCIDENT?
YES ☐ ☐ NO

16. IF AN ACCIDENT: Date _____
TIME _____ ☐ A.M. ☐ P.M.
DESCRIPTION: _____

17. IF THE CLAIM SUBMITTED IS A LABORATORY TEST OR DOCTOR'S OFFICE VISIT, STATE DIAGNOSIS OR NATURE OF ILLNESS _____

18. To all physicians and other health professionals, and all hospitals and other health care institutions:
You are authorized to provide North Broward Hospital District (NBHD), Total Claims Administration, Inc. (TCA) and any independent claim administrators and consulting health professionals and utilization review organizations with whom NBHD has contracted, information concerning health care, advice, treatment or supplies provided the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits.
TCA may provide NBHD with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the policy or contract.
This authorization is valid for the term of coverage of the plan under which a claim has been submitted.
I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date: _____ Patient's or Authorized Person's Signature: _____

19. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.*

SIGNED (Employee or Authorized Person) Date _____

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO EMPLOYEE)

1. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

2. DATE FIRST CONSULTED YOU FOR THIS CONDITION

3. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

4. IF AN EMERGENCY CHECK HERE ☐

5. DATE PATIENT ABLE TO RETURN TO WORK

6. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

7. NAME OF REFERRING PHYSICIAN (e.g., PUBLIC HEALTH AGENCY)

8. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

9. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

10. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ☐ ☐ NO CHARGES

11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (PLEASE INDICATE PRIMARY AND SECONDARY DIAGNOSIS)

1

2

3

4

12. **PROCEDURES, MEDICAL SERVICES, SUPPLIES FURNISHED**

DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE** IDENTIFY	DESCRIPTION OF SERVICE	TYPE OF SERVICE†	CHARGES	DAYS OR UNITS	DIAGNOSIS CODE††	ADMINISTRATIVE USE ONLY

13. NAME OF PHYSICIAN OR SUPPLIER

14. Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.

15. TOTAL CHARGE

16. AMOUNT PAID

17. BALANCE DUE

18. ADDRESS ☐ CHECK IF NEW

19. TELEPHONE NO.

20. PHYSICIAN'S OR SUPPLIER'S SIGNATURE DATE

21. PATIENT ACCOUNT NO.

*PLACE OF SERVICE CODES

1 - (IH) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - Day Care 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 Medical Surgical Facility
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Facility

† TYPE OF SERVICE CODES

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
M - Alternate Payment for Maintenance Dialysis
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

**PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY

††PLEASE USE ICD-9-CM FOR DISCHARGE DIAGNOSIS

Total Claims Administration, Inc.

HOW TO REQUEST BENEFITS

1. COMPLETE THE "PATIENT INFORMATION" (ITEMS 1 THROUGH 18) ON THE REVERSE SIDE OF THIS FORM.

   If you want your medical benefits paid directly to your doctor, sign item 19. A separate form should be submitted for each family member.

2. HAVE YOUR DOCTOR COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION" (ITEMS 1 THROUGH 21) OR SUBMIT COMPLETELY ITEMIZED BILLS.

   An itemized bill is one that shows the patient's name, relationship to employee/retiree, date of service, the type of service rendered, the nature of the condition being treated, and the physician's or supplier's taxpayer identification number, if benefits are assigned. If this information is missing, please write it on the bill yourself and sign your name.

3. SEND THE COMPLETED "CLAIM" FORM AND THE BILLS DIRECTLY TO:

   TOTAL CLAIMS ADMINISTRATION, INC.
   P.O. BOX 21128
   FORT LAUDERDALE, FL 33335-1128

NOTE: Any person who knowingly and with intent to defraud or deceive any third party administrator, insurance company or self insured health plan, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

IMPORTANT REMINDER

Please be sure you have provided the **employee/retiree's Social Security Number.**

You may wish to accumulate small bills and submit them to TCA when you have met your deductible.

If you are covered under Medicare or have any other medical coverage, be sure to attach a copy of any bill(s) you have submitted to the other carrier and the Explanation of Benefits form you received for those bills.

DDH/mvf
PM-2/HPCF.PM3
PS-2030