INTERNATIONAL BENEFITS ADMINISTRATORS L.L.C
100 GARDEN CITY PLAZA, SUITE 110
GARDEN CITY, NY 11530

MEDICAL CLAIM FORM

NOTE: If all questions are not answered, there may be a delay in processing this claim, and this form may be returned to you for completion.

EMPLOYER'S NAME MUST BE COMPLETED OR CLAIM WILL NOT BE PROCESSED

EMPLOYEE'S STATEMENT PLEASE PRINT OR TYPE

FOR ALL CLAIMS	NAME OF EMPLOYEE	MARRIED ☐ SINGLE ☐	EMPLOYEE'S SOCIAL SECURITY NUMBER	
	EMPLOYEE'S ADDRESS / CITY / STATE		TELEPHONE	DATE OF BIRTH
IF THIS CLAIM IS FOR A DEPENDENT	NAME OF DEPENDENT	MARRIED ☐ SINGLE ☐	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH
	IF CLAIM IS FOR A CHILD OVER 19 YEARS IS THAT CHILD A FULL TIME STUDENT? IF YES, WHERE?			

HAS EMPLOYEE'S SPOUSE OR UNMARRIED CHILDREN BEEN EMPLOYED IN THE LAST 12 MONTHS	YES ☐ NO ☐	NAME AND ADDRESS OF DEPENDENTS PRESENT(OR) LAST EMPLOYER

DATE ACCIDENT OR SICKNESS BEGAN	DATE LAST WORKED	DATE FIRST TREATED

NATURE OF SICKNESS OR INJURY	IF INJURED, HOW AND WHERE DID THE ACCIDENT HAPPEN?
PHYSICIANS NAME AND ADDRESS FIRST CONSULTED	IF CONFINED IN THE LAST 12 MONTHS NAME AND ADDRESS OF HOSPITAL. DATES OF CONFINEMENT
NAME AND ADDRESS OF HOSPITAL, IF CONFINED	DATES OF CONFINEMENT

CLAIM NUMBER	YES	NO	DID INJURY OR ILLNESS ARISE DUE TO:	YES	NO
DID YOU PREVIOUSLY SUBMIT A CLAIM?	☐	☐	A. PATIENTS OCCUPATION	☐	☐
IF YES, GIVE CLAIM NUMBER.					
☐ CHECK HERE IF UNKNOWN			B. AUTOMOBILE ACCIDENT	☐	☐

ARE YOU OR YOUR DEPENDENT INSURED FOR HOSPITAL, SURGICAL OR MEDICAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER EMPLOYER, UNION, STUDENT, ASSOCIATION, BLUE CROSS BLUE SHIELD, MEDICARE, OR ANY OTHER GROUP INSURANCE PLAN? IF YES, PLEASE INSERT POLICY NUMBER, NAME, ADDRESS AND TELEPHONE NUMBER OF INSURANCE COMPANY OR ORGANIZATION PROVIDING SUCH BENEFITS OR SERVICES:

☐ YES

☐ NO

POLICY NUMBER	NAME AND ADDRESS	TELEPHONE NUMBER

I hereby certify that the statements herein and attached are to the best of my belief accurate, and I herby authorize my physician, hospital, pharmacy, insurance company, employer or organizations to release any information regarding the medical history, treatment, disability or benefits payable to this claim, to IBA or its representatives. I acknowledge and agree that the plan is subrogated to my rights against any third party to the extent of any payments by the plan. A photostat of this authorization shall be as valid as the original.

Any person knowingly and with intent to defraud any insurance company or other person, files a statement or claim containing any material false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act and is subject to civil or criminal penalty.

Employee's Signature

Signature (Patient if 18 or older)

DATE

PART A

AUTHORIZATION OF PAYMENT TO PROVIDERS:
I hereby authorize payment of medical benefits to
undersigned physician or supplier for services described below:

Signed (Patient or Parent if minor)

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the undersigned Physician to release any
information aquired in the course of my examination or treatment:

Signed (Patient or Parent if minor)

PART B ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CURRENT CONDITIONS (If diagnosis code other than ICDA* used, give name):

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENTS EMPLOYMENT?

PREGNANCY? YES ☐ NO ☐

IF YES, APPROX DATE PREGNANCY COMMENCED:

DATE:

3. REPORT OF SERVICES (or attach itemized bill) (If your previous form submitted to this carrier, you need to show only dates and services since last report.)

DATE OF SERVICE	Place of Service	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODES- IF USED (If code other than CPT used, give name)	CHARGES

O- Doctors Office
H- Patients Home
ICDA- Int'l Classification of disease
CPT- Current Procedure Terminology

IH- Inpatient Hospital
OH- Outpatient Hospital
NH- Nursing Home
OL- Other Location

Total Charges:
Amount Paid:
Balance Due:

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED?

5. DATE PATIENTS FIRST CONSULTED YOU FOR THIS CONDITION?

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?
☐ YES ☐ NO IF YES, WHEN AND DESCRIBE:

7.PATIENT STILL UNDER CARE FOR THIS CONDITION?
☐ YES ☐ NO

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)
FROM THRU

9. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

10. DOES PATIENT HAVE OTHER HEALTH COVERAGE? IF YES, PLEASE IDENTIFY.
☐ YES ☐ NO

DATE	PHYSICIANS NAME	SIGNATURE	TELEPHONE

STREET ADDRESS	CITY	STATE	ZIP

DOCTORS SOCIAL SECURITY NUMBER: ______________________
OR
TAX PAYER'S IDENTIFICATION NUMBER: ______________________