the first REHABILITATION LIFE INSURANCE COMPANY of AMERICA
600 NORTHERN BLVD
GREAT NECK NY 11021-5202
(800) 365-4999 FAX(516) 829-8213

GROUP EXCESS MEDICAL

STATEMENT OF CLAIM FOR CO-INSURANCE BENEFITS

TO FILE
ATTACH COPIES OF
PAYMENT STATEMENTS
FROM ALL OTHER CARRIERS

EMPLOYER'S CERTIFICATION

Employer's Name	Employer's Address (Street, City, State, Zip Code)	Policy Number 1127-02
Employee's Name(Last, First, Middle Initial)	Date Employed	Occupation
Employee's Social Security No	Date Employee Insured	Date Dependents Insured
Employee's Status ☐ Active ☐ Retired	Type of Excess Coverage ☐ Individual ☐ Family	If Coverage is terminated, give date
Signature & Title of Authorized Person		Date

EMPLOYEE'S STATEMENT (Complete for all claims)

Employee's Name (Last, First, Middle Initial)		Employee's Address (Street, City, State, Zip Code)
Employee Date of Birth	Employee's Social Security No	Telephone No.
Claims for ☐ Self ☐ Spouse ☐ Child	Patient's Name (Last, First, Middle)	Employee's Status ☐ Male ☐ Single ☐ Divorced ☐ Widow ☐ Female ☐ Married ☐ Seperated ☐ Widower
Patient's Date of Birth	Is Patient on Medicare? ☐ Yes ☐ No	

COMPLETE IF EMPLOYEE IS MARRIED

Name of Spouse	Spouse Social Security No	Is Spouse Employed? ☐ Yes ☐ No
If you answered "Yes" to the previous question, give name, address and phone number of spouse's employer		
Name(s) and Address(es) of spouse's health insurance carrier(s)		Policy Number(s)
Spouse's Insurance I.D. Number	Spouse's Coverage ☐ Individual ☐ Family	Are there any other health insurance benefits available from any other source? ☐ Yes ☐ No If "Yes" please give details in space below

COMPLETE IF CLAIM IS FOR YOUR DEPENDENT CHILD

Child's Name	Indicate if child is ☐ Student ☐ Married ☐ Handicapped	Child lives at ☐ Home ☐ School
If Child is in school and between ages 18 and 25, give school name and address		
Is child employed? ☐ Yes ☐ No		
If "Yes" give name and address of employer		
Employer's Phone No	Name of child's health insurance carrier and policy number	

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containg 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

COMPLETE FOR ALL CLAIMS

I hereby authorize any Insurance Company, Prepayment Organization, Employer or provider of medical services to releases all information with respect of myself or my dependents, which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information given by me in support of this claim is true and correct. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Dependent Signature (If patient and not minor) Date and Employee Signature

Health Insurance
Claim Form

TO BE COMPLETED BY THE ATTENDING PHYSICIAN (If benefits to be assigned)

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT NAME (First name, middle initial, last name)	2 PATIENT'S DATE OF BIRTH	3 INSURED'S NAME (First name, middle initial, last name)
4 PATIENT'S ADDRESS (Street, city, state, Zip Code)	5 PATIENT'S SEX MALE FEMALE	6 INSURED'S I D No (Soc Sec No)
	7 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER	8 INSURED'S GROUP NO (Or Group Name)
9 OTHER HEALTH INSURANCE COVERAGE Enter Name of Name and Address and Policy or Medical Assistance Number	10 WAS CONDITION RELATED TO A PATIENT'S EMPLOYMENT YES NO B AN AUTO ACCIDENT YES NO	11 INSURED'S ADDRESS (Street, city, State, Zip code)
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the Release of any Medical information Necessary to process this claim SIGNED DATE		13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY(ACCIDENT) OR PREGNANCY (LMP)	15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO	
17 DATE PATIENT ABLE TO RETURN TO WORK	18 DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH	
19 NAME OF REFERRING PHYSICIAN		20 FOR SERVICES RELATED TO HOSPITALIZATION ADMITTED DISCHARGED	
21 NAME 7 ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES	

23 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

24 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	F

25 SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE		26 TOTAL CHARGES	27 AMOUNT PAID 28 BALANCE DUE
	29 YOUR SOCIAL SECURITY NO	30 PHYSICIAN'S OR SUPPLIER'S NAME ADDRESS ZIP CODE & TELEPHONE NO	
31 YOUR PATIENT'S ACCOUNT NO	32 YOUR EMPLOYER I D NO	I D NO	

* PLACE OF SERVICE CODE

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