HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT

TEACHERS PROTECTIVE MUTUAL LIFE INSURANCE COMPANY
116 N. Prince St. Box 597 Lancaster, Pa. 17603

PATIENT & INSURED (SUBSCRIBER) INFORMATION

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

2. PATIENT'S DATE OF BIRTH

3 INSURED'S NAME (First name, middle initial, last name)

NOT APPLICABLE

5. PATIENT'S SEX — MALE ☐ ☐ FEMALE

6.

7 PATIENT'S RELATIONSHIP TO INSURED — SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8 INSURED'S POLICY NUMBER

9 OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan 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 GIVE HOSPITALIZATION DATES — ADMITTED — DISCHARGED

21 NAME & 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. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY)
NOT APPLICABLE

30. YOUR SOCIAL SECURITY NO

27 TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO

32 YOUR PATIENT'S ACCOUNT NO

33. YOUR EMPLOYER I.D. 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
O — (OL) — OTHER LOCATIONS
A — (IL) — INDEPENDENT LABORATORY
B — OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74