Integrity Administrators, Inc.

PO Box 13128, Sacramento, CA 95813-3128 Ph. (800) 562-9383

CLAIM FORM – TO BE USED WHEN THE PROVIDER DOES NOT BILL DIRECTLY

To be used for a non-occupational sickness or accident claim.

After completing this form, please attach all bills/receipts and forward this form to Integrity Administrators, Inc..

EMPLOYEE INFORMATION: Sex: Male ☐ Female ☐

Name:_____ Social Security No.___--___--___

Address:_____ Home Phone:(___)_____

City:_____State:_____Zip:_____ Employer:_____

PATIENT INFORMATION:

1. Relationship to Employee: **A.** Self ☐ Spouse ☐ Child ☐ Other ☐ **B.** Sex: Male ☐ Female ☐

2. Patient Status: **A.** Single ☐ Married ☐ Other ☐ **B.** Employed ☐ Full time Student ☐ Part time Student ☐

Name:_____Birth Date:_____ Social Security No.___--___--___

Address:_____ Home Phone:(___)_____

City:_____State:_____Zip:_____ Employer:_____

Students Age 19 to 23: Number of Hours

Name of School:_____Number of Units: Worked Per Month _____

IS PATIENT'S CONDITION RELATED TO:

1. Employment?:(Current or Previous) Yes ☐ No ☐ **2.** Auto Accident? Yes ☐ No ☐ State ____ **3.** Other Accident? Yes ☐ No ☐

IF THIS CLAIM IS FOR AN ACCIDENT:

Where did it occur?_____Date of Accident:_____

Cause of Accident? _____

NATURE OF AILMENT:

Date of First Treatment:_____ Briefly describe condition: _____

OTHER COVERAGE INFORMATION:

Is the person for whom this claim is made, covered under any other group insurance, HMO or health service plan? Yes ☐ No ☐

Is the person for whom this claim is made, covered under any school or student plan? Yes ☐ No ☐

Name of Other Plan: _____ Policy No. _____

Address of Other Plan: _____

Name of Other Employer or School: _____

Other Insured's Name:_____Social Security No. ___--___--___

AUTHORIZATION TO PAY BENEFITS: I authorize payment of medical benefits to physician or supplier of service.

Employee's Signature	Date	Patient's Name	Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, dentist, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, employer, union or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment for me, my spouse or my dependent children and any other non-medical information of me, my spouse or my dependent children to give to the Trustees or Plan Sponsor of the Welfare Plan (hereinafter called The Plan) or its legal representative, any and all such information in connection with my claim.

I UNDERSTAND the information obtained by use of the Authorization will be used by the Plan, its Trustees or its authorized claims paying administrator to determine eligibility for benefits or services under the Plan. Any information obtained will not be released by the Plan to any person or organization EXCEPT to persons or organizations performing direct administrative, professional, medical or legal services IN CONNECTION WITH MY CLAIM, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be valid for three years from the date shown below.

Employee's Signature	Date	Patient's Name	Date