Keenan HealthCare

HEALTH BENEFIT CLAIM FORM

PLAN SPONSER	Prime Healthcare	CLAIM PROCESSING SERVICES BY	Keenan HealthCare

PLEASE COMPLETE PART 1, 2 AND 3 OF THIS FORM IN DETAIL

HOW TO FILE A CLAIM

- Complete your portion of this "Claim Form". Be sure to answer all questions to avoid delay in payment of benefits.
- Ask your doctor to complete the "Attending Physician's Statement" portion of this form.
- Attach itemized medical/surgical bill(s) not reported on the Attending Physician's statement.
- Each bill or statement must describe name of patient, nature of surgical or medical procedures and other services or supplies furnished as well as date and amount charged for each.
- If your Plan provides coverage for prescription drugs, submit itemized bills with this form.

WHERE TO FILE A CLAIM

Keenan HealthCare, Benefit Claims Department, P.O. Box 2744, Torrance, CA 90509, 888.773.7218, Fax 310.212.3381

EMPLOYEE INFORMATION

PART 1

EMPLOYEE'S NAME	MALE/FEMALE	DATE OF BIRTH / /	SOCIAL SECURITY # OR ALTERNATE ID

EMPLOYEE'S STREET ADDRESS	CITY	STATE	ZIP CODE	HOME TELEPHONE NUMBER

YOUR OCCUPATION	NAME OF FACILITY WHERE EMPLOYED

ARE YOU MARRIED? ☐ YES ☐ NO	DATE OF BIRTH / /	NAME AND ADDRESS OF SPOUSE'S EMPLOYER

IS THE PATIENT, OR ANY FAMILY MEMBER ENROLLED IN AN HMO, PPO OR COVERED UNDER ANY MEDICAL, OR OTHER GROUP INSURANCE PLAN? ☐ YES ☐ NO	IF YES, GIVE NAME AND ADDRESS OF HMO, PPO FACILITY, EMPLOYER OR OTHER GROUP INSURANCE CO.

DEPENDENT INFORMATION

PART 2

IS CLAIM FOR A DEPENDANT? ☐ YES ☐ NO	NAME OF THE DEPENDANT, IF OTHER THAN SPOUSE	DEPENDENT'S RELATIONSHIP TO EMPLOYEE

DEPENDENT'S DATE OF BIRTH / /	IS THIS DEPENDENT MARRIED? ☐ YES ☐ NO	IF DEPENDENT IS A FULL-TIME STUDENT, GIVE NAME/ADDRESS OF SCHOOL

IS DEPENDENT EMPLOYED? ☐ YES ☐ NO	IF YES, GIVE NAME AND ADDRESS OF EMPLOYER

PART 3

IS THIS CLAIM DUE TO AN ACCIDENT? ☐ YES ☐ NO	IF YES, DATE OF ACCIDENT / /	WAS A MOTOR VEHICLE INVOLVED? ☐ YES ☐ NO

DID THIS ACCIDENT OCCUR DURING YOUR COURSE OF EMPLOYMENT? ☐ YES ☐ NO	WHERE DID THIS ACCIDENT HAPPEN?

DESCRIBE HOW THE ACCIDENT HAPPENED:

PART 4

I certify the above is complete and correct and I am claiming benefits only for charges incurred by the patient named above.

Authorization is hereby given to any hospital, physician, or other provider that participated in any way with the care and treatment, insurance company including a prepaid health plan, employer or group policyholder, contract holder or benefit plan administrator, to release to the above named Plan Administrator any medical information and any employment information regarding the patient, which they in their judgement deem necessary to evaluate and administer claim benefits. I know I have a right to receive a copy of this authorization and that its photographic copy is as valid as the original.

SIGNATURE (PATIENT, OR PARENT IF MINOR)	DATE

Keenan
HealthCare

HEALTH BENEFIT CLAIM FORM

INSTRUCTIONS FOR PROVIDER(S) OF MEDICAL CARE

Please complete this form or send an itemized statement of charges showing
(1) Insured's Name (2) Patient's Name (3) Insured's Employer (4) Diagnosis

SEND TO: Keenan Healthcare, Benefit Claims Department, P.O. Box 2744, Torrance, CA 90509

NOTE: IF YOU HAVE A DOCTOR'S BILL CONTAINING THE INFORMATION REQUESTED BELOW, YOU MAY ATTACH IT TO THIS FORM RATHER THAN COMPLETING THE FORM ITSELF.

AUTHORIZATION TO PAY PROVIDER:	I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE PROVIDER OF ANY BENEFITS OTHERWISE PAYABLE TO ME UNDER THE PLAN.
EMPLOYEE'S SIGNATURE	DATE

ATTENDING PHYSICIAN'S STATEMENT (TO BE COMPLETED BY ATTENDING PHYSICIAN OR SUPPLIER OF SERVICES)

PATIENT'S NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	RELATIONSHIP TO EMPLOYEE	EMPLOYEE'S SOCIAL SECURITY NO.

WAS CONDITION RELATED TO:	HAVE YOU COMPLETED ANY OTHER CLAIM FORMS FOR THIS ILLNESS OR INJURY? ☐ YES ☐ NO
☐ PATIENT'S EMPLOYMENT	DO YOU HAVE ANY KNOWLEDGE OF THE PATIENT HAVING OTHER INSURANCE? ☐ YES ☐ NO
☐ AN AUTO ACCIDENT	IF YES, PLEASE IDENTIFY
☐ PREGNANCY	

DATE OF 1ST SYMPTOM OR ACCIDENT	WAS LABORATORY WORK PERFORMED OUTSIDE OF YOUR OFFICE? ☐ YES ☐ NO	CHARGE $

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?	NAME AND ADDRESS OF REFERRING PHYSICIAN
FOR SERVICES RELATED TO HOSPITALIZATION: DATE ADMITTED	DATE DISCHARGED ☐ YES ☐ NO	NAME AND ADDRESS OF FACILITY
DATE(S) OF TOTAL DISABILITY: FROM: / / THROUGH: / /		DATE PATIENT IS ABLE TO RETURN TO WORK

DIAGNOSIS (ICD-9-CM) (IF MORE THAN ONE CONDITION, PLEASE RELATE DIAGNOSIS TO PROCEDURE(S) USING ICD-9-CM CODE(S) TO FIFTH DIGIT IF APPLICABLE)

IF MORE THAN ONE CONDITION, PLEASE RELATE DIAGNOSIS TO PROCEDURE(S) USING ICD-9-CM CODE

PLACE OF SERVICE CODES: IH - INPATIENT HOSPITAL; OH - OUTPATIENT HOSPITAL; O - DOCTOR'S OFFICE; H - PATIENT'S HOME; NH - NURSING HOME; SNF - SKILLED NURSING FACILITY; OL - OTHER LOCATIONS; IL - INDEPENDENT LABORATORY

DATE OF SERVICE	DIAGNOSIS CODE	PLACE OF SERVICE	DESCRIPTION OF SERVICE	PROCEDURE CODE (CPT-4)	CHARGES

PHYSICIAN'S OR SUPPLIER'S NAME	SOCIAL SECURITY NO.	TOTAL CHARGE $
STREET ADDRESS	EMPLOYER/TAX IDENTIFICATION NO.	AMOUNT PAID $

CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )	BALANCE DUE $

SIGNATURE OF PHYSICIAN OR SUPPLIER	DATE