

PLEASE DO NOT  
STAPLE IN  
THIS AREA



FORM APPROVED  
OMB NO. 0938-0088

<input type="checkbox"/> MEDICARE (MEDICARE NO.)	<input type="checkbox"/> MEDICAID (MEDICAID NO.)	<input type="checkbox"/> CHAMPUS (SPONSOR'S SSN)	<input type="checkbox"/> CHAMPVA (VA FILE NO.)	<input type="checkbox"/> FECA BLACK LUNG (SSN)	<input type="checkbox"/> OTHER (CERTIFICATE SSN)
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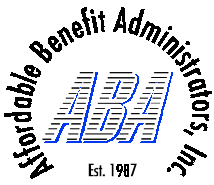
**PATIENT AND INSURED (SUBSCRIBER) INFORMATION**

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS)
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.) <input type="checkbox"/> INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
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 <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>	11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)  TELEPHONE NO.
12. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.	SIGNED _____ DATE _____	11a. CHAMPUS SPONSOR'S: STATUS: <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> DECEASED <input type="checkbox"/> RETIRED BRANCH OF SERVICE _____
		13. I AUTHORIZE THE RELEASE 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. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES	16a. IF EMERGENCY CHECK HERE <input type="checkbox"/>
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 OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES:	
23. A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE 1, 2, 3, ETC. OR DX CODE			B. EPSDT YES <input type="checkbox"/> NO <input type="checkbox"/> FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/>	
1. _____ 2. _____ 3. _____ 4. _____			PRIOR AUTHORIZATION NO. _____	
24. A. DATE OF SERVICE FROM _____ TO _____		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	H. LEAVE BLANK
			E. CHARGES	F. DAYS OR UNITS
			G.* TOS	
25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)		26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE
DATE: _____		30. YOUR SOCIAL SECURITY NO.		28. AMOUNT PAID
32. YOUR PATIENT'S ACCOUNT NO.		33. YOUR EMPLOYER I.D. NO.		29. BALANCE DUE
				31. PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
				I.D. NO.

\* PLACE OF SERVICE AND TYPE OF SERVICE (TOS)



MAIL TO  
 ABA, Inc.  
 P.O. Box 10787  
 Burbank, CA 91510-0787  
 1 (800) 350-0148

## MEDICAL CLAIM

### EMPLOYEE'S INSTRUCTIONS FOR FILING A CLAIM

YOUR CLAIM WILL BE SUBJECT TO DELAY OR MAY BE RETURNED IF THESE INSTRUCTIONS ARE NOT FOLLOWED. USE A SEPARATE FORM FOR EACH MEMBER OF THE FAMILY AND FOR EACH SEPARATE ILLNESS OR ACCIDENT. ADDITIONAL BILLS FOR THE SAME PERSON MAY BE SUBMITTED COMPLETING **ONLY** THE EMPLOYEE SECTION OF THE CLAIM FORM.

Complete every applicable entry on this form.

Have the reverse side of this form completed by your primary attending physician. Ask other providers of service to give you an **ITEMIZED BILL**. Receipts and cancelled checks are not acceptable.

### TO BE COMPLETED BY THE EMPLOYEE

- A. Employee's name \_\_\_\_\_  Male  Female Date of Birth \_\_\_\_\_
- B. Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_
- C. Employer name and address \_\_\_\_\_ Date hired \_\_\_\_\_
- D. Have you terminated employment?  Yes  No If yes, date \_\_\_\_\_ Social Security # \_\_\_\_\_
- E. Marital Status \_\_\_\_\_ Name of spouse \_\_\_\_\_ Is spouse employed?  Yes  No
- F. Name and address of spouse's employer \_\_\_\_\_
- G. Is condition work related?  Yes  No Have you filed for Worker's Compensation benefits?  Yes  No
- H. Is condition related to accident or injury?  Yes  No Date first symptoms of illness or injury appeared \_\_\_\_\_
- I. If yes to G or H, please give detailed description \_\_\_\_\_  
 \_\_\_\_\_
- J. Have you/dependent previously been treated for this or a related medical problem?  Yes  No  
 If yes, state when and give name(s) of doctor(s) and hospital(s)  
 \_\_\_\_\_
- K. Are you or any of your dependents entitled to benefits under any other group plan?  Yes  No
- If yes, give name of: Employer: \_\_\_\_\_  
 Person carrying other coverage \_\_\_\_\_  
 Insurance company \_\_\_\_\_  
 Policy number \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Address of Claims Paying Office \_\_\_\_\_

### COMPLETE THE FOLLOWING QUESTIONS ONLY IF CLAIM IS FOR A DEPENDENT

- L. Dependent's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_
- M. Is the child 19 years old or older?  Yes  No If so, is (s)he a full-time student  Yes  No
- Name of school \_\_\_\_\_ Marital Status \_\_\_\_\_

### AUTHORIZATION

Upon presentation of this original or a photocopy thereof, I authorize any medical professional, medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Affordable Benefit Administrators, Inc. or any agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, with all information regarding advice, care treatment and diagnosis about any medical condition, including use of drugs or alcohol concerning the patient herein. I also authorize any patient's or member's employer, group policyholder or benefit plan administrator to provide Affordable Benefit Administrators, Inc., or the above-named parties with all other medical or employment information relevant to this claim. I understand that Affordable Benefit Administrators, Inc. will use such information for evaluation and administration of claims for insurance benefits; I have a right to receive a copy of this authorization upon request; and this authorization is valid from the date signed for the duration of the claim. I certify the information given by me is true and correct.

EMPLOYEE'S SIGNATURE

DATE

PATIENT'S SIGNATURE (Guardian to sign if parent is under age 15)

DATE