

CLAIM FOR HEALTH CARE BENEFITS

MHI, Inc. HEALTH INSURANCE PLAN

1	Employee's Name (Please Print Full Legal Name)			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		Marital Status		First Name of Spouse																			
	Employee's Birthdate		Mo Day Yr		Policy or Group #		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Spouse's Birthdate																		
	Home Address		No. Street		City State Zip		Is Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No																				
							Name and Address of Company where Spouse is Employed																				
	Employee's Social Security Number		<table border="1" style="width:100%; height:20px;"> <tr> <td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td> </tr> </table>												Spouse's Social Security Number		<table border="1" style="width:100%; height:20px;"> <tr> <td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td><td style="width:20px;"></td> </tr> </table>										

2	Patient's Name (If other than employee)		Patient's Birthdate		Mo Day Yr		Date Covered		Relationship to Employee		If Child Is (s)he married?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If child is 19 or over, is (s)he dependent upon your maintenance and support?		Is (s)he a full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name and location of school.										

3	Date injury occurred or illness began.		If accident, where and how it occurred.									
	Was illness or injury due, in any way, to the patient's occupation?		Was more than one family member involved in accident?									
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name(s).									
		Was this an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No										

4	Is patient covered by another group employer plan or any other prepayment arrangement maintained on a group basis?																	
	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please furnish name and address of employer, insurance company or governmental agency, type of coverage and policy number:																	
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align:center;">Effective Date</td> </tr> <tr> <td colspan="2" style="text-align:center;">Is COBRA Applicable</td> </tr> <tr> <td colspan="2" style="text-align:center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td colspan="2" style="text-align:center;">Effective Date of COBRA</td> </tr> </table>										Effective Date		Is COBRA Applicable		<input type="checkbox"/> Yes <input type="checkbox"/> No		Effective Date of COBRA	
	Effective Date																	
Is COBRA Applicable																		
<input type="checkbox"/> Yes <input type="checkbox"/> No																		
Effective Date of COBRA																		
Does other group coverage include a pre-existing coverage limitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If eligible, is person enrolled in: Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of Part A is _____ Medicare Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of Part B is _____																		
If these expenses are covered by other insurance and the other carrier is primary (that is, pays first), do not file this claim until you have received the payment from the other carrier? Submit the explanation of benefits from the other carrier with this claim.																		

5	AUTHORIZATIONS: (TO BE COMPLETED BY THE PATIENT AND EMPLOYEE)									
	AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Hospital or Physician to release information required in the course of my examination or treatment which may be necessary to determine benefits payable under this plan. (A photostatic copy of this authorization is as valid as the original.)					SIGNED (PATIENT OR PARENT, IF MINOR)				
						DATE				
	AUTHORIZATION TO ASSIGN BENEFITS: I here authorize payment directly to the Physician and/or Hospital providing services for which benefits are payable. This authorization is invalid unless the Tax I.D. of the provider is given.					SIGNED (COVERED EMPLOYEE)				
					DATE					

6	Does your claim contain the following information: Diagnosis, date of service, procedure, other insurance EOB, provider's address? For faster service, please make sure all of the above are included with your claim.									
	Mail completed form to: Kanawha HealthCare Solutions, Inc. Group Benefits P. O. Box 1000 Lancaster, SC 29721									

PHYSICIAN'S STATEMENT

1. Date		Illness (first symptoms) OR Injury OR Pregnancy (LMP)		2. Date you were first consulted for this condition		3. Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Date patient able to return to work		5. Dates of total disability From _____ Through _____				6. Dates of partial disability From _____ Through _____			
7. Name of referring physician						8. For services related to Admitted hospitalization give hospitalization dates Discharged			
9. Name & address of facility where services rendered (if other than home or office)						10. Was laboratory work performed outside your office? <input type="checkbox"/> Yes <input type="checkbox"/> No			
11. Diagnosis or nature of illness or injury, relate diagnosis to procedure in COLUMN D by reference to number 1, 2, 3, etc. or DX code Note: If possible please give CPT-4 procedure code in "C" below and ICD-9 in "D". 1. _____ 3. _____ 2. _____ 4. _____									
12. A Date of Service	B Place of Service	C Procedure Code (Identify: _____)		D Diagnosis Code		E Charges		F	
Fully describe procedures, medical services or supplies furnished for each date given Explain unusual services or circumstances)									
13. Signature of Physician or Supplier				14. Accept Assignment If yes, Tax I.D. Number must Be given below <input type="checkbox"/> Yes <input type="checkbox"/> No		15. Total Charges		16. Amt. Pd	17. Bal. Due
Signed		Date		18. Physician Social Security No.		19. Physician's or Supplier's name, address, zip code & telephone number			
20. Patient's Account No.				21. Physician's Tax ID No.		ID No.			