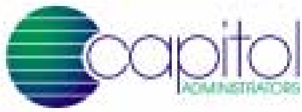

HEALTH INSURANCE CLAIM FORM

SUBMIT ALL CLAIMS TO: **Capitol Administrators, Inc., P.O. Box 2318**
Rancho Cordova, CA 95741-2318
For Information call (800) 331-5301

IMPORTANT INSTRUCTIONS

- **USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY TYPE OR PRINT ALL INFORMATION**
- **FILL IN ALL ITEMS COMPLETELY (WHERE APPLICABLE)**
- **SIGN AND DATE THE FORM IN THE SPACES PROVIDED**
- **IF CAPITOL IS YOUR SECONDARY INSURANCE, ATTACH A COPY OF THE EXPLANATION OF BENEFITS (EOB) FROM YOUR PRIMARY CARRIER**
- **ATTACH THE ORIGINAL ITEMIZED BILL(S) FOR THE SERVICES OF THIS PROVIDER (WE CANNOT ACCEPT 'BALANCE STATEMENTS', CASH REGISTER OR CREDIT CARD RECEIPT(S)**

EMPLOYER'S NAME

NAME OF EMPLOYEE	DATE OF BIRTH (Month, day, year)	SEX

HOME ADDRESS STREET OR P.O. BOX NUMBER	CITY	STATE	ZIP CODE

EMPLOYEE'S SOCIAL SECURITY NO.	OCCUPATION	☐ MARRIED ☐ SINGLE	☐ WIDOWED ☐ DIVORCED

NAME OF SPOUSE	DATE OF BIRTH (Month, day, year)	IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO	IF YES, NAME AND ADDRESS OF EMPLOYER

IS THE PATIENT, OR ANY FAMILY MEMBER ENROLLED IN AN HMO, PPO OR COVERED UNDER ANY MEDICAL, DENTAL 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

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

DEPENDENT'S DATE OF BIRTH (Month, day, year)	IF DEPENDENT IS A FULL-TIME STUDENT, GIVE NAME AND ADDRESS OF SCHOOL

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)E

4. PATIENT'S ADDRESS (Street, City, State, Zip code)	5. PATIENT'S SEX ☐ M ☐ F	6. INSURED'S I.D., MEDICARE AND OR MEDICAID NO. (Include any letters)
	7. PATIENT'S RELATIONSHIP TO INSURED	INSURED'S GROUP NO. (or Group Name)

9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder, Plan Name, address and policy number	10. WAS CONDITION RELATED TO: ☐ PATIENT'S EMPLOYMENT ☐ AN AUTO ACCIDENT	11. INSURED'S ADDRESS (Street, City, State, Zip Code)

12 - 13 I certify the above is complete and correct and I am claiming benefits only for charges by the patient named above.

Authorization is hereby given to any hospital, physician, or other provider which participated in any way with the care and treatment, or insurance company prepaid health plan, employer or group policyholder, contract holder or benefit plan administrator to release to the above Plan Administrator any medical information and any employment information regarding the patient, which they in their judgment deem necessary to evaluate and administer claim benefits. This authorization is valid for the duration of the claim.

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 (Insured or Authorized Person)	DATE

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 THIS PLAN

SIGNATURE (Insured or Authorized Person)	DATE

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF 1ST SYMPTOM-ACCIDENT	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS

17. DATE(S) OF TOTAL DISABILITY FROM THROUGH	18. DATE PATIENT ABLE TO RETURN TO WORK

19. NAME OF REFERRING PHYSICIAN OR FACILITY	20. FOR SERVICES RELATED TO HOSPITALIZATION DATE ADMITTED DATE DISCHARGED

21. NAME AND ADDRESS OF FACILITY	22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ❑ YES ❑ NO	CHARGE $

23. 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 CODE	IH – INPATIENT HOSPITAL OH – OUTPATIENT HOSPITAL O – DOCTOR'S OFFICE	H – PATIENT'S HOME NH – NURSING HOME SNK – SKILLED NURSING FACILITY	OL – OTHER LOCATIONS IL – INDEPENDENT LABORATORY

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

PHYSICIAN'S OR SUPPLIER'S NAME			SOCIAL SECURIY 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