STATEMENT OF CLAIM

Mail completed Form to: Health Cost Solutions
P.O. Box 1439, Hendersonville, TN 37077
Phone: (615) 822-0483

TO BE COMPLETED FOR ALL EMPLOYEE-SUBMITTED CLAIMS

Employer Name _____

Employee's Name _____ Social Security Number _____ Date of Birth _____

Employee's Address _____

Spouse's Name _____ Social Security Number _____ Date of Birth _____

Claim is made for: ☐ Self ☐ Single

(check one) ☐ Dependent _____ ☐ Married

(Name of Dependent) (Relationship) (Date of Birth) (Sex)

Is dependent employed? Yes ☐ No ☐ If "Yes" give name and address of Employer _____

_____

Is this disability due to Claimant's occupation Yes ☐ No ☐ If "Yes", explain _____

First full day unable to work _____ Date resumed work _____ Date expected to resume work _____

ARE YOU, YOUR SPOUSE, OR CHILDREN INSURED UNDER ANY OTHER PLAN OF INSURANCE? Yes ☐ No ☐

If "Yes" complete the following:

A. Is this other insurance through an employer or U.S. Government Yes ☐ No ☐ If "yes" complete (a)
   (a) Employer's Name or Government Service _____
B. Group or
   Policy No. _____ Contract No. _____
C. Indicate which member of family is covered: ☐ Self ☐ Spouse ☐ Children
D. Name and address of Insurance Company _____

COMPLETE WHEN ACCIDENT IS INVOLVED	Date of accident _____ Location of accident _____. Describe accident in detail _____. _____.
COMPLETE WHEN SICKNESS IS INVOLVED	Nature of sickness: _____. Date symptoms first appeared: _____ .

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish Health Cost Solutions with full information regarding treatment rendered (including copies of records). I also authorize any Union Trust Fund Association, Employer, Doctor, Hospital or Insurance Carrier to furnish the Health Cost Solutions with information regarding benefits to which I may be entitled. Photostatic copy hereof shall be as valid as the original.

_____ _____

Employee's Signature Date

PART A TO BE COMPLETED BY PATIENT (INSURED)

PATIENT'S NAME AND ADDRESS

MEMBER'S NAME

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize copayment directly to the undersigned Physician of the Surgical and/or Medical Benefits. If any, otherwise payable to me for the services as described below but not to exceed the reasonable and customary charge for those services.

SIGNED (INSURED PERSON)

DATE

AUTHORIZED TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment

SIGNED (PATIENT, OR PARENT IF MINOR)

DATE

PART B ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES ☐ NO ☐

PREGNANCY? YES ☐ NO ☐

IF YES, APPROXIMATE DATE PREGNANCY COMMENCED. DATE

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT.)

DATE OF SERVICES	PLACE OF SERVICES †	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE – IF USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)	CHARGES
			TOTAL CHARGES	
			AMOUNT PAID	
			BALANCE DUE	

†O – Doctor's Office IH – Inpatient Hospital NH – Nursing Hospital
H – Patient's Home OH – Outpatient Hospital OL – Other Locations
*ICDA – International Classification of Diseases
**CPT – Current Procedural Terminology (current edition)

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?: YES ☐ NO ☐ IF "YES" WHEN AND DESCRIBE:

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?: YES ☐ NO ☐

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED. (UNABLE TO WORK) FROM THRU

9. PATIENT WAS PARTIALLY DISABLED. FROM THRU

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

11. Doctor's Taxpayer ID No. ☐☐☐☐☐☐☐☐☐
Check which: Social Security No. Employer ID No.

12. DOES PATIENT HAVE OTHER COVERAGE? YES ☐ NO ☐ IF "YES" PLEASE IDENTIFY

13. I DO NOT ACCEPT ASSIGNMENT ☐

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE TELEPHONE

STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE