AdventistHealth

MEDICAL CLAIM FORM

1. COMPLETE THIS FORM
2. ATTACH ALL BILLS, RECEIPTS AND/OR INVOICES
3. MAIL TO:
   Benefits Administration
   P.O Box 619031
   Roseville, CA 95661-9031

PHONE: 800-441-2524

NOTE: YOU MUST SUBMIT A SEPARATE FORM FOR EACH MEDICAL CLAIM.

PART 1 – GENERAL INFORMATION:

EMPLOYEE NAME:	HEALTH PLAN ID:	GROUP #:
HOME ADDRESS:	EMPLOYEE BIRTH DATE:	
CITY, STATE, ZIP CODE	PHONE NUMBER: ( )	

PART 2 – PATIENT NAME

PATIENT NAME::	BIRTH DATE:	RELATIONSHIP TO EMPLOYEE SPOUSE ( ) CHILD ( )

PART 3 – OTHER INSURANCE INFORMATION

SPOUSE'S NAME:	SPOUSE'S BIRTH DATE:	MEDICAL ID:	EMPLOYER:	
INSURANCE COMPANY NAME	ADDRESS:	CITY, STATE, ZIP	PHONE #:	GROUP #:

PART 4 - AUTHORIZATIONS, PATIENT TO SIGN (PARENT, IF A MINOR).

AUTHORIZATION FOR RELEASE OF INFORMATION:

For the purpose of determining eligibility for benefits and claims processing, I hereby authorize Benefits Administration to receive from and/or provide to medical practitioners, medically related facilities, insurance companies, or my employer, information as to any physical or mental condition of myself or my covered dependents. I know I have a right to receive a copy of this Authorization. I agree that a photographic copy is as valid as the original and that it shall be valid for two (2) years and six (6) months from the date shown below.

Patient Signature (Parent, if a minor) Date

PART 5 - ATTACH BILLS, RECEIPTS, AND/OR INVOICES

ATTACH BILLS, RECEIPTS AND/OR INVOICES FOR REIMBURSEMENT TO PATIENT.

PART 6 - PROVIDER/FACILITY INFORMATION

DATE OF SERVICE	TYPE/PLACE OF SERVICE	DIAGNOSIS CODE:	CPT CODE:
OFFICE TAX ID #		TOTAL CHARGES:	

Revised: 12/2020