MedCost Benefit Services
d/b/a MBS Third Party Administrators in California
P.O. Box 25987
Winston-Salem, NC 27114-5987
(336) 774-4400 Fax (336) 774-4420
1-800-795-1023

MEDCOST℠ BENEFIT SERVICES

STATEMENT OF MEDICAL CLAIM

GROUP # _____

EMPLOYEE INFORMATION

EMPLOYEE NAME (LAST, FIRST, MI)	MEMBER ID	DATE OF BIRTH / /	MALE ☐ FEMALE ☐

EMPLOYEE ADDRESS (CHECK HERE IF NEW ADDRESS ☐) CITY STATE ZIP

ARE YOU STILL EMPLOYED? YES ☐ NO ☐
IF "NO" DATE TERMINATED:

SPOUSE INFORMATION

SPOUSE NAME (LAST, FIRST, MI)	MEMBER ID	DATE OF BIRTH / /

SPOUSE'S EMPLOYER'S NAME ADDRESS CITY STATE ZIP

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED UNDER ANY OTHER MEDICAL PLAN? YES ☐ NO ☐ IF YES, PLEASE COMPLETE:

PARTICIPANT NAME_____ CARRIER NAME_____ GROUP #_____

CARRIER ADDRESS_____

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI)	PATIENT RELATIONSHIP: SELF ☐ CHILD ☐ SPOUSE ☐ OTHER ☐	DATE OF BIRTH / /

IF DEPENDENT OVER AGE 19, COMPLETE FULL TIME STUDENT INFORMATION: SCHOOL NAME ADDRESS PHONE

IF ACCIDENT, IS INJURY RELATED TO PATIENT'S EMPLOYMENT? YES ☐ NO ☐ OR AUTO ACCIDENT? YES ☐ NO ☐
HOW, WHEN AND WHERE DID THE ACCIDENT HAPPEN?

HAS PATIENT BEEN PREVIOUSLY TREATED FOR THIS CONDITION? YES ☐ NO ☐
IF YES, GIVE FIRST TREATMENT DATE:

I authorize any physician, medical practitioner, hospital facility, consumer reporting agency, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my minor children to MedCost Benefit Services or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medial history, mental or physical condition, or treatment of me or my minor children. I understand that MedCost Benefit Services will not release any information obtained by this authorization to any person or organization except reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully required or permitted, or as I may further authorize, I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be valid as the original. I agree that this authorization shall be valid for the duration of my claim.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Employee's Signature _____ Date _____

Patient's Signature _____ Date _____

I authorize payment of medical benefits directly to the providers of service.

Employee's Signature _____ Date _____

Provider of Service:
Please complete form or attach itemized bill.

MEDCOST℠ BENEFIT SERVICES

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other 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 _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . ___ 3. ____ . ___

2. ____ . ___ 4. ____ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY **AMA** COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90). FORM RRB-1500.
APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)