BSI Companies

Statement of Claim for Group Medical Benefits
Mail to: Post Office Box 6708
Greenville, SC 29606
Telephone: 1-888-298-6828
Fax: 1-864-467-9489

HOW TO FILE A CLAIM: Complete this side of form and top portion of reverse side for assignment of benefits. benefits.
Have the attending physician complete his portion of reverse side if you do not have the billing.

NAME AND ADDRESS OF EMPLOYER		EMPLOYEE STATUS ACTIVE ☐ RETIRED ☐
ABOUT THE EMPLOYEE	Name_____ Soc. Sec. No. _____ Address_____	☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated Date of Birth ___/___/____
ABOUT THE EMPLOYEE'S SPOUSE	Name of Spouse_____Birthdate___/___/____ Is Spouse Employed? ☐ Yes ☐ No Spouse's Employment Status? ☐ Active ☐ Retired Does Spouse's Employer Provide Group Insurance? ☐ Yes ☐ No Is Your Spouse Covered By That Plan? ☐ Yes ☐ No	Name & Address of Spouse's Employer _____ _____ _____ _____
ABOUT THE PATIENT	This Claim is For: ☐Myself *If disabled, 1st day not worked ___/___/___ Expected Return___/___/___ ☐My Spouse_____Date of Birth __/__/__ ☐My Child Name_____Date of Birth__/__/__	Is Child Employed? ☐ Yes ☐ No Employer or School Name_____ City_____ State_____
ABOUT THE CLAIM	This Claim is Due To: (complete question 1, and either 2A or 2B) 1. Is this condition related to your job? ☐ Yes ☐ No	2A. AN ACCIDENT Nature of Injury?_____ _____ How did it Happen?_____ _____ Where_____When__/__/__ First Physician Consultation/Visit? __/__/__	2B. AN ILLNESS Nature of Illness_____ When Did Symptoms Begin? __/__/__ First Physician Consultation/Visit?__/__/__ Name of Physician_____ Address_____ _____
ABOUT OTHER INSURANCE	Is the Patient Covered by One or More of the Following? Any other group insurance? ☐ Yes ☐ No Any federal, state or other government plan, or union welfare plan? ☐ Yes ☐ No Any medical plan sponsored by a school or college? ☐ Yes ☐ No Any auto insurance if an injury? ☐ Yes ☐ No		
	If "Yes" to any of the Above, Name & Address of the Other Insurance Company? _____ _____	Name of Insured _____ Policy # or Certificate	Name & Address of Employer, Group or School Providing Plan _____ _____

Certification & Authorization (to be signed by the patient {or parent if patient is minor} and the certificate holder)
I hereby certify that the above answers and statements hereon and attached are to the best of my belief accurate. I hereby authorize any hospital, physician or other insurance company to furnish BSI Companies or its representative or permit said company or its representative to review any information requestion with respect to any illness or accident, medical history or copies of hospital and medical records or other company records. A photocopy of this authorization shall be considered as valid as the original.

Date ___/___/___

Patient's Signature_____ Employee Signature_____

******INCOMPLETE ANSWERS MAY DELAY PROCESSING***

ASSIGNMENT OF BENEFITS

I hereby direct that all hospital benefits due me be paid directly to (name and address of hospital) _____ _____ _____ Signature of Insured Person_____	I hereby direct that all surgical or medical benefits due me be paid directly to (name and address of physician) _____ _____ _____ Signature of Insured Person_____
Please reimburse me for benefits due and I understand I am financially responsible for any expenses due the provider of service. Signature of Insured Person_____	Please reimburse me for benefits due and I understand I am financially responsible for any expenses due the provider of service. Signature of Insured Person_____

PHYSICIAN OR SUPPLIER INFORMATION

14. Date of Illness (first symptom) or injury (accident) or pregnancy (LMP): ___/___/___	15. Date first consulted you for this condition: ___/___/___	16. Has patient ever had same or similar symptoms? ☐ Yes ☐ No
17. Date patient able to return to work? ___/___/___	18. Date of Total Disability? From ___/___/___ Through ___/___/___	19. Date of Partial Disability? From ___/___/___ Through ___/___/___
20. Name of Referring Physician? _____ _____		21. For services realted to hospitalization, give hospitalization dates? Admitted ___/___/___ Discharged ___/___/___
22. Name and Address of Facility where services rendered (if other than office)? _____ _____		23. Was laboratory work performed outside your office? ☐ Yes ☐ No Charges? _____

24. Diagnosis or nature of illness or injury. Relate diagnosis in column D by reference number 1, 2, 3, etc. or DX code

1
2
3
4

Date of Service	Place of Service	Procedure Code	Fully describe procedures, medical services or supplies furnished for each given date	Diagnostic Code	Charges	Comments

25. Signature of Physician or Supplier Signed_____Date___/___/___	26. Accept assignment (government claims only) ☐ Yes ☐ No	27. Total Charge:	28.Amnt. Pd.	29. Bal. Due

30. Your Social Security # or Employers ID #: _____ ****Must be furnished under authority of law.**	31. Patient's account #: _____	32. Physician's or Supplier's name, address, zip code & telephone number. _____ _____

Place of Service Codes

1-(IH)Inpatient Hospital	4-(H)Patient's Home	7-(NH)Nursing Home	10-(OL)Other Locations
2-(OH)Outpatient Hospital	5-(PSY)Day Care Facility	8-(SNF)Skilled Nursing Facility	11-(IL)Independent Labs
3-(O)Doctor's Office	6-(PSY)Night Care Facility	9-(AM)Ambulance	12-(OMS)Other Medical/Surgical Facility

**For surgical procedure code, please use California Relative Value Study or equivilant: for Diagnosis Code ICDA revision 8.

Approved by AMA Council on Medical Service 6-74