

# Medical Claim Form



KAISER PERMANENTE®

Please follow the instructions on the reverse side of this form.

Kaiser Permanente Insurance Company

## Employee information

Employee's name (last, first, middle initial)	Purchaser ID:	Employee's Social Security number/Medical Record Number
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Employee's home address (street, city, state, ZIP code)

Employee's date of birth	Employee's home telephone number ( )	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> Legally separated
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Name and address of employer	Employee's occupation
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Do you have more than one employer?  Yes  No If YES, give full name and address of other employer:

Is your spouse employed?  Yes  No If YES, give name and address of employer:

Are you entitled to reimbursement of all or part of these expenses through any other coverage that provides medical benefits or services?  
 Yes  No If YES, please provide us with the name, address, policy number, and effective date of the other carrier.

## Patient information

(If patient and employee are the same, patient information does not have to be completed.)

Patient's name (last, first, middle initial)	Date of birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
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Patient's home address (street, city, state, ZIP code)	Patient's relationship to employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
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If full-time student, give school name and city

## Claim information

Nature of illness/reason for service	Has Health International been contacted for precertification? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Is this claim based on an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, complete the following:	
Date of accident:	Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Describe how, when, and where accident occurred:
Was injury related to an auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Are any of the illnesses or injuries for which this claim is being made related to employment?  Yes  No

Is this claim for preadmission testing?  Yes  No

### Authorization signature for information release

I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacy to release any information requested by Kaiser Permanente Insurance Company. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Patient's signature, if claim is for dependent other than minor child: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Signature of employee: \_\_\_\_\_

### If payment is to be made to the provider, please sign below:

I hereby authorize payment of benefits to any providers of services otherwise payable to me for services but not to exceed the Usual, Customary, and Reasonable Charges for these services. I understand that I am financially responsible for any charges not covered by this authorization.

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Signature of employee: \_\_\_\_\_

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

## How to file your claim:

1. Answer all questions and sign the *"Authorization signature for information release"* on the reverse side of this form.
2. Attach itemized bills—**important**—each bill must show (a) name of patient, (b) date each expense was incurred, and (c) nature of illness or injury.
3. Forward completed claim form and bills to:

Kaiser Permanente Insurance Company  
P.O. Box 261155  
Plano, TX 75026