Mail claims to:

HealthComp Administrators

P.O. Box 45018, Fresno, CA 93718-5018

For questions, call: 855-727-5267

MEDICAL CLAIM FORM

HealthComp
Third Party Administrators

Group Name: USC **Subscriber ID Number: JEX** [ ][ ] - [ ][ ][ ][ ][ ][ ][ ] **Group Number:** S C 1

PATIENT AND EMPLOYEE INFORMATION

1. Patient's Name	2. Patient's Date of Birth (mm/dd/yyyy)	3. Employee's Name
4. Patient's Address (Street, City, State, Zip Code)	5. Patient's Gender ☐ Male ☐ Female 7. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Registered Domestic Partner	6. Employee's Address (Street, City, State, Zip Code) ☐ Check here if new address

8. Other Health Insurance Coverage → Is Patient covered by any other plan (including Medicare)? ☐ Yes ☐ No

If "Yes", provide name and address of carrier: _____

Types of coverage by carrier: ☐ Medical ☐ Drug ☐ Dental ☐ Vision

Identification or Social Security Number: _____

Effective date of other coverage: _____ Termination date of other coverage: _____

9. I authorize the undersigned physician to release any information acquired in the course of my examination or treatment.	10. I authorize payment of medical benefits to the undersigned physician or supplier for service(s) described below.
Signed (Patient): Date:	Signed (Patient): Date:

PHYSICIAN OR SUPPLIER INFORMATION

11. Date of illness (first symptom) or injury (accident) or pregnancy (mm/dd/yyyy)	12. Date Patient first consulted you for this condition (mm/dd/yyyy)
13. Was condition related to Patient's employment? ☐ Yes ☐ No	14. Was condition related to an accident? ☐ Yes ☐ No
15. If accident related, please give details:	
16. For services relating to hospitalization, give hospitalization dates	Admitted: / / Discharged: / /
17. Name and address of facility where services rendered:	18. Was lab or x-ray work performed outside your office? ☐ Yes ☐ No Charges: $

19. Diagnosis or nature of illness or injury (relate diagnosis to procedure in Column E below)

20. Place of Service Codes *

1. Inpatient hospital	5. Day care facility	9. Ambulance	C. Residential treatment center
2. Outpatient hospital	6. Night care facility	O. Other location	D. Specialized treatment center
3. Doctor's office	7. Nursing care	A. Independent lab	E. Comprehensive O/P Rehab
4. Patient's home	8. Skilled nursing facility	B. Amb. surgery ctr.	F. Ind. Kidney disease treat. ctr.

21. A Date of Service (mm/dd/yyyy) FROM TO	B* Place of Service	C CPT-4 Procedure Code	D Fully describe procedures, medical services or supplies furnished for each date given (explain unusual services or circumstances)	E Diagnosis Code	F Charges	G Days or Units

22. Signature of Physician or Supplier (incl. degrees or credentials) Date:	23. Physician's, supplier's and/or group name, address, zip code and telephone no.	24. Total Charges:	Balance Due
26. Patient's account number:		25. Taxable entity name (if different than Box 23):	
		27. Provider's tax identification number:	