

FHA-TPA

Benefit Administrators

INSTRUCTIONS:
 1. Complete the Member's Statement below. Have patient's physician complete Part C.
 2. Attach itemized bills for expenses not shown on Part C.
 3. Return form and attachments to
FHA-TPA
PO Box 327810
Fort Lauderdale, FL 33332-9998

CLAIM FORM
 Group Hospital-Surgical-Medical

(PLEASE PRINT)	PART A	TO BE COMPLETED BY THE EMPLOYEE:	
1. Name of the Employee	Name of Group	Social Security Number	
City & State	Zip	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <input type="checkbox"/> Married <input type="checkbox"/> Single
3. Claim is made for: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Unmarried Child (check one) <input type="checkbox"/> Unmarried Student attending (Name of School) _____ Is spouse or child covered by their employer? <input type="checkbox"/> Yes <input type="checkbox"/> No Employer Name _____			
4. Name of dependent for whom claim is being made		Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
5. Nature of Illness			
Date a doctor was first seen on this condition		Doctors Name and Address	
Was hospital consignment required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Hospital	
Has a doctor been seen for this or a similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s): _____			
Doctors Name and Address			
6. Name and Address of family doctor			
7. If claim is based on an accident:			
Was the accident due to injured person's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date occurred	Time	Where and accident occur?	
How did accident happen?			
8. Is claimant entitled to additional benefits under.		Yes	No
a. Group insurance or any other arrangement of coverage for individuals in a group?		<input type="checkbox"/>	<input type="checkbox"/>
b. Blue Cross, Blue Shield or any other prepayment arrangement?		<input type="checkbox"/>	<input type="checkbox"/>
c. Any federal, state or other governmental program?		<input type="checkbox"/>	<input type="checkbox"/>
If answer to any of above is yes complete the following.		Policy No.	
Insured	Name & Address of Insurance company of organization		
You			
Spouse			
Child			
I hereby certify that the foregoing statements, including any accompanying statements are true and complete to the best of my knowledge. I hereby authorize any physician, hospital, insurance company, organization or employer to release any information including full copies or their records to Florida Health Administrators, Inc. FHA-TPA Division for any medical treatment, services of benefits rendered or payable to me (or my dependents). A copy of this authorization shall be as valid as the original.			
Signature of employee		Patient's signature (if other than employee)	
Date			

TO BE COMPLETED BY PATIENT

PATIENT'S NAME AND ADDRESS		DATE OF BIRTH
EMPLOYEE'S NAME IF PATIENT IS A DEPENDENT		
RETURN TO: FHA-TPA Benefit Administrators P.O. Box 327810 Fort Lauderdale, FL 33332-9711	GROUP NAME	EMPLOYEE'S SOCIAL SECURITY NUMBER

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for this services as described below but not to exceed the reasonable and customary charge for those services. ▶ SIGNED (EMPLOYEE)

Continuing Authorization is Release Information. I hereby authorize the undersigned physician /hospital to release any an/or information required and to be acquired. In the course of his/her examination or treatment. ▶ SIGNED (PATIENT, OR PARENT IF MINOR)

PART C ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(If diagnosis code other than ICDA used, give name)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? Yes No PREGNANCY ? Yes No IF YES APPROXIMATE DATE PREGNANCY COMMENCED DATE

3. REPORT OF SERVICES (or attach remitted bill) (if previous form submitted to the carrier, you need show only dates and services since last report).

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE IF USED OF CODE OTHER THAN	CHARGES

DO – Doctor's Office IH – Independent Hospital NH – Nursing Home H – Patient's Home OH – Outpatient Hospital OL – Other Locations ** ICDA – International Classification of diseases ** ICPT – Current Procedural Terminology (current edition)	TOTAL CHARGES \$ AMOUNT PAID \$ BALANCE DUE \$
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4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES" WHEN AND DESCRIBE	7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (Unable to Work) FROM _____ THRU _____	9. PATIENT WAS PARTIALLY DISABLED FROM _____ THRU _____
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK. _____	11. PATIENT WAS HOUSE CONFINED FROM _____ THRU _____
12. DOES PATIENT HAVE OTHER HEALTH COVERAGE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES" PLEASE IDENTIFY	Individual Practitioner – SSN _____ All Other – Employer I.D. No. _____ Must be furnished under authority of law _____
13. NAME AND ADDRESS OF REFERRING PHYSICIAN:	

14. NAME AND ADDRESS OF ATTENDING PHYSICIAN _____ TELEPHONE _____

15. ATTENDING PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN RETURNING THIS FORM TO: **FHA-TPA**
PO Box 327810
Fort Lauderdale, FL 33332-9998

