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 | ☐ Male ☐ Female | Date of Birth | ☐ Married ☐ Single

3. **Claim is made for:** ☐ Self ☐ Spouse ☐ Unmarried Child
   (check one) ☐ Unmarried Student attending (Name of School) ______
   Is spouse or child covered by their employer? ☐ Yes ☐ No Employer Name ______

4. **Name of dependent for whom claim is being made** | Date of Birth | ☐ Male ☐ Female

5. Nature of Illness

Date a doctor was first seen on this condition | Doctors Name and Address

Was hospital consignment required? ☐ Yes ☐ No | Name of Hospital

Has a doctor been seen for this or a similar condition in the past? ☐ Yes ☐ 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? ☐ Yes ☐ 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?	☐	☐
b. Blue Cross, Blue Shield or any other prepayment arrangement?	☐	☐
c. Any federal, state or other governmental program?	☐	☐

If answer to any of above is yes complete the following.

Insured	Name & Address of Insurance company of organization	Policy No.
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 undesigned 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 $ ....

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?
   ☐ Yes ☐ No If "YES" WHEN AND DESCRIBE

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
   ☐ Yes ☐ 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?
    ☐ Yes ☐ 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