PLEASE SUBMIT ORIGINAL ITEMIZED BILLS WITH A COMPLETED AND SIGNED CLAIM FORM!

IMPORTANT: These forms are electronically scanned, please do not use HIGHLIGHTER or anything else that might distort the information on this form.

TYPE OR PRINT

IDA Insurance Design Administrators

Post Office Box 875, Oakland, NJ 07436
800 / 225-1345 or 201/ 337-0555
See reverse side for claim filing information

MEDICAL CLAIM 875

PATIENT INFORMATION (TO BE COMPLETED BY INSURED)

1. INSURED'S Employer | 2. INSURED'S Soc. Sec. No. | 3. INSURED'S Name, Address and Phone No. ☐ If this is a new address, you must notify your employer

4. PATIENT'S Name (First name, middle initial, last name) | 5. PATIENT'S Date of Birth

6. PATIENT'S Sex ☐ M ☐ F | 7. PATIENT'S relation to INSURED ☐ self ☐ spouse ☐ child ☐ other | 8. PATIENT'S Status: a ☐ Single ☐ Married ☐ Other b. Employed full-time Yes ☐ No ☐ c. Student full-time Yes ☐ No ☐

9. Is PATIENT'S condition related to:
a. ☐ Employment? (Current or Previous)
b. ☐ Auto Accident? Place _____ (State)
c. ☐ Other Accident?
d. If injured:
→ Describe how and where ▶
→ Date _____
→ Will you sue?
YES ☐ NO ☐

10. PATIENT'S Address (If different from INSURED'S) and Phone No. ☐ If this is a new address, you must notify your employer

11. INSURED'S Date of Birth | 12. INSURED'S Sex ☐ M ☐ F | 13. Is INSURED Now actively at work? ☐ YES ☐ NO or under ☐ COBRA | 14. Date INSURED'S hired

15. OTHER HEALTH INSURANCE COVERAGE - SECTIONS BELOW MUST BE ANSWERED FOR CLAIM TO BE APPROVED. ◀

A. INSURED'S SPOUSE'S employer (If unmarried or spouse is unemployed check none)

☐ None Employer Name _____ Phone _____

Street _____ City _____ State ____ Zip _____

B. Name and address of other insurance company or H.M.O. If none, check None

☐ None

C. Name of person covered - last & first | Date of Birth / / | Sex ☐ M ☐ F | Policy No. Identification

D. Person covered & named in item "C " above is insured's: ☐ Self ☐ wife ☐ Husband ☐ Daughter ☐ Son ☐ Other (Describe)

16. I authorize the release of any medical information necessary to process this request

Signed (PATIENT or Authorized person) Date

17. I authorize payment of benefits directly to the Physician or Supplier named below.

Signed (INSURED or Authorized person)

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO INSURED)

DATE OF CURRENT: { ILLNESS (First symptom) or INJURY (Accident) or PREGNANCY (LMP) | IF PATIENT HAS HAD SAME OR SIMILAR SYMPTOMS, GIVE FIRST DATE CONSULTED | HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO | DATES OF TOTAL DISABILITY FROM TO | DATES OF PARTIAL DISABILITY FROM TO

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | OUTSIDE LAB USED? YES ☐ NO ☐ | NAME AND ADDRESS OF FACILITY WHERE SERVICES WHERE RENDERED (If other than home or office)

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Reference 1,2,3 or 4 to PROCEDURE in DIAGNOSIS CODE column)

1. 3.

2. 4.

DATES OF SERVICE FROM	TO	PLACE* OF SERVICE	PROCEDURE CODE	EXPLANATION OF SERVICES	DIAGNOSIS CODE	$ CHARGES		DAYS OR UNITS

FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

PHYSICIAN OR SUPPLIER NAME, ADDRESS AND PHONE NUMBER

ACCEPT ASSIGNMENT? YES ☐ NO ☐

PATIENT'S ACCT. No.

TOTAL CHARGES		
AMOUNT PAID		
BALANCE DUE		

SIGNATURE DATE

* PLACE OF (IH) INPATIENT (OV) DOCTOR'S OFFICE (DCF) DAY CARE FACILITY (IL) INDEPENDENT LAB (OL) OTHER LOCATION

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION WITH THE INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR PERSON IS GUILTY OF A FELONY.

1. COMPLETE THE **"PATIENT INFORMATION"** SECTION (ITEMS 1 THROUGH 14) ON THE REVERSE SIDE OF THIS FORM

   If you wish your medical benefits paid directly to your doctor, sign ITEM 17. A separate form must be submitted for each family member.

2. HAVE YOUR DOCTOR COMPLETE THE **"PHYSICIAN OR SUPPLIER INFORMATION"** SECTION OR SUBMIT COMPLETELY ITEMIZED BILLS.

   An itemized bill is one that shows the PATIENT'S name, relationship to INSURED, date of service, type of service rendered, and the nature of the condition being treated

3. THE COMPLETED FORM AND ITEMIZED BILLS MUST BE SENT TO THE ADDRESS BELOW:

SUBMIT ALL MEDICAL CLAIM FORMS TO:

INSURANCE DESIGN ADMINISTRATORS
P.O. BOX 875
OAKLAND, NJ 07436

ELIGIBILITY AND ALL OTHER INQUIRIES CALL: 1-800-225-1345

IMPORTANT REMINDER

Please be sure you have provided the INSURED'S Social Security Number.

NOTE TO CLAIMANT

Please attach all itemized bills and supporting documents to this completed and signed claim form. Do not use highlighter or anything else that might distort the information on this form; **otherwise, your claim will be delayed.**

NOTE TO ATTENDING PHYSICIAN

If the PATIENT named will be under continuous treatment for the stated condition, there will be no need to fill out an ATTENDING PHYSICIAN'S statement each time a bill is submitted. An itemized bill will be acceptable for processing. However, if the patient consults you for any other condition, a new ATTENDING PHYSICIAN'S statement will be necessary.

INCOMPLETE CLAIM FORMS WILL BE RETURNED FOR COMPLETION. ALSO, IF YOU OR YOUR IMMEDIATE FAMILY ARE COVERED BY ANY OTHER INSURANCE PROGRAMS, INCLUDING MEDICARE, THE **"OTHER HEALTH INSURANCE COVERAGE" SECTION** MUST BE COMPLETED EACH TIME YOU SUBMIT A CLAIM FORM OR YOUR FORM WILL BE RETURNED.