Send Medical Claims to:

Physicians' Benefits Trust
P.O. Box 909786-60690
Chicago, IL 60690

Phone Numbers:

Fax: **312-906-8359**
Toll Free: **800-621-0748**

MEDICAL CLAIM FORM

INSTRUCTIONS: Complete the form below. Please see the reverse side for more detailed instructions. Return the completed form to Physicians' Benefits Trust

STATEMENT OF CLAIM FOR HEALTH BENEFITS

1. CLAIM IS BEING MADE FOR:
   [ ] Insured [ ] Unmarried Child. If child is 25 or over, benefits continued as [ ] Full time student, attending _____ School
   [ ] Spouse [ ] Other

2. PATIENT'S NAME: DATE OF BIRTH: / / SEX:

3. IS THIS CLAIM DUE TO AN ACCIDENT? IF YES, WHERE DID ACCIDENT OCCUR? DATE OF ACCIDENT: / /
   [ ] Yes [ ] No
   DESCRIBE ACCIDENT:

4. IS THIS CLAIM AS A RESULT OF A WORK RELATED ILLNESS OR INJURY? [ ] Yes [ ] No

5 IF YES, HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? [ ] Yes [ ] No

6. IS THE PATIENT COVERED UNDER ANY OTHER PLAN PROVIDING HEALTH BENEFITS? [ ] Yes [ ] No
   IF "YES", PROVIDE THE NAME AND ADDRESS OF THE COMPANY OR INSURANCE CARRIER PROVIDING BENEFITS:

   NAME OF COMPANY OR INSURANCE CARRIER (Area) TELEPHONE NUMBER

   STREET NUMBER CITY STATE ZIP

7. INSURED'S NAME (PLEASE PRINT) (Area) TELEPHONE NUMBER

   STREET NUMBER CITY STATE ZIP

8. AUTHORIZATION TO RELEASE INFORMATION:
   I hereby certify that the foregoing statements are true and correct to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Physicians' Benefits Trust any and all information with respect to any illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

   PATIENT'S SIGNATURE DATE
   (If other than Insured, omit if patient is a minor.)

   INSURED'S SIGNATURE DATE

9. ASSIGNMENT OF BENEFITS:
   I hereby authorize payment directly to the provider of medical services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.

   INSURED'S SIGNATURE DATE

revised 3/08

A-6333-408

INSTRUCTIONS FOR FILING A CLAIM

COMPLETE INSURED STATEMENT: PLEASE BE SURE TO ANSWER EVERY QUESTION.

All bills must show patient's name, date(s) of treatment, nature of treatment (diagnosis) and fee for each service.

If a claim is for prescription drugs, attach bills to form after completing "Insured's Statement of Claim" section. All bills must show: patient's name; prescription number; date(s) of purchase; and charge.

If claim is for registered nurses, x-ray, laboratory or medical equipment, attach bills to the form after completing "Insured's Statement of Claim" section. All bills must show: patient's name; nature and date(s) of service; amount of charge; and prescribing physician. Additional data will be requested if needed.

This list follows the numerical order on the claim form:

1.) *Check the appropriate box for whom the claim is being made.*

2.) *Provide the patient's name, date of birth, and sex.*

3.) *Check the appropriate box (yes or no) if the claim is due to an accident. State where the accident occurred and the date of the accident. Please provide a brief description of the accident.*

4.) *Check the appropriate box (yes or no) if the claim is work related.*

5.) *If the patient is eligible for benefits under another plan, please check the appropriate box and provide the name and address of the insurance carrier or company providing the other benefits for the patient.*

6.) *Provide the Insured's name and address.*

7.) *Sign and date the claim form.*

8.) *Sign and date the Assignment of Benefits, if applicable.*

Mail the claim form and the itemized bill to Physicians' Benefits Trust P.O. Box 909786-60690, Chicago, IL 60690. KEEP A COPY FOR YOUR RECORDS.

IMPORTANT ITEMS TO NOTE

1.) All charges must be submitted within the time frame specified in the certificate. Failure to do so will result in the denial of the charges.
2.) From time to time, additional information may be requested in order to process a claim. Any additional information, i.e., other insurance payments, completed claim forms, subrogation forms, accident details, police reports, etc., must be submitted when requested. Failure to do so may result in the denial of the claim.
3.) ALWAYS retain a copy for your records.