MAIL CLAIM FORM TO:

PITTMAN & ASSOCIATES, INC.
P O Box 111047
Memphis, Tennessee 38111
(901) 323-2140

STATEMENT OF CLAIM FOR HOSPITAL, SURGICAL OR MEDICAL BENEFITS

TO BE COMPLETED BY COVERED EMPLOYEE

STATEMENT OF EMPLOYEE

(PRINT CLEARLY)					ALWAYS ENTER YOUR
EMPLOYEE LAST NAME	FIRST	MIDDLE	MARITAL STATUS		GROUP NO.
					SOCIAL SECURITY NO.
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER ( )	SPOUSE'S DATE OF BIRTH / /
NAME OF PATIENT TREATED	☐ EMPLOYEE ☐ SPOUSE ☐ CHILD ☐ OTHER		☐ MARRIED ☐ SINGLE	☐ MALE ☐ FEMALE	PATIENT'S DATE OF BIRTH / /
IF PATIENT IS CHILD OVER AGE 19 IS HE/SHE ATTENDING SCHOOL? ☐ YES ☐ PART TIME ☐ NO ☐ FULL TIME	NAME AND ADDRESS OF SCHOOL OR COLLEGE				
NATURE OF SICKNESS, INJURY OR DIAGNOSIS. IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?					
DATE ACCIDENT OR SICKNESS BEGAN	DATE FIRST TREATED		IS THIS CONDITION DUE TO ANY OCCUPATIONAL INJURY OR DISEASE? ☐ YES ☐ NO		
PHYSICIAN NAME	PHYSICIAN ADDRESS				
IS YOUR SPOUSE OR ANY FAMILY MEMBER EMPLOYED? ☐ YES ☐ NO. IF "YES", SHOW SPOUSE/FAMILY MEMBER NAME AND NAME AND ADDRESS OF EMPLOYER(S).					
DOES PATIENT HAVE MEDICARE? ☐ YES ☐ NO			EFFECTIVE DATE / /		
ARE YOU OR ANY FAMILY MEMBER ENROLLED OR COVERED UNDER ANY TYPE OF EMPLOYER, UNION, STUDENT, ASSOCIATION GROUP PLAN OR GOVERNMENT PROGRAM THAT PROVIDES BENEFITS FOR THIS CONDITION? ☐ YES ☐ NO. IF "YES", COMPLETE THE FOLLOWING:					
NAME OF OTHER PLAN, INSURANCE CARRIER, GOVERNMENT PROGRAM OR HMO			ADDRESS (NO. & STREET)		
POLICY OR PLAN NO.	IDENTIFICATION NO.	PHONE NUMBER ( )	CITY	STATE	ZIP
These statements are true and complete to the best of my knowledge. Date _____ Signature of Employee _____					

I certify that the above statements and answers, including any accompanying bills and statements are true and complete to the best of my knowledge and belief. I authorize the release to and the use by Pittman & Associates, Inc., of any medical or other information needed in processing this claim. A photocopy of this authorization shall be valid as the original.

IF CLAIM IS ON A DEPENDENT OVER 18 YEARS OF AGE, THIS MUST BE SIGNED BY BOTH THE EMPLOYEE AND DEPENDENT.

Date _____ Signature of Employee _____ Dependent _____

Attach **original** itemized medical or drug bills.

ATTENDING PHYSICIAN STATEMENT

PATIENT INFORMATION

1. PATIENT'S NAME (First name, middle, last name)	2. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. SIGNED (Employee or authorized person)

ATTENDING PHYSICIAN (OR SUPPLIER) INFORMATION

DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	DATE YOU WERE FIRST CONSULTED FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OF SIMILAR SYMPTOMS? YES ☐ ☐ NO
DATE PATIENT ABLE TO RETURN TO WORK	DATE OF TOTAL DISABILITY FROM ___ THROUGH ___	DATES OF PARTIAL DISABILITY FROM ___ THROUGH ___
NAME OF REFERRING PHYSICIAN		FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED ___ DISCHARGED ___
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*		WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE

1.

2.

3.

4.

5.

6.

A DATE OF SERVICE	B * PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F

SIGNATURE OF PHYSICIAN (OR SUPPLIER) SIGNED DATE	MEDICARE PATIENT ONLY Accept Assignment? YES ☐ ☐ NO YOUR SOCIAL SECURITY NO.	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE
YOUR PATIENT'S ACCOUNT NO.	YOUR EMPLOYER I.D. NO.	PHYSICIAN'S (OR SUPPLIER'S) NAME, ADDRESS, ZIP CODE & TELEPHONE NO. I.D. NO.		

* PLACE OF SERVICE CODES

1—(H)	—INPATIENT HOSPITAL	4—(H)—	PATIENT'S HOME	7—(NH)	—NURSING HOME	0—(OL)	—OTHER LOCATIONS
2—(OH)	—OUTPATIENT HOSPITAL	5—	DAY CARE FACILITY (PSY)	8—(SNF)	—SKILLED NURSING FACILITY	A—(IL)	—INDEPENDENT LABORATORY
3—(O)	—DOCTOR'S OFFICE	6—	NIGHT CARE FACILITY (PSY)	9—	AMBULANCE	B—	OTHER MEDICAL/SURGICAL FACILITY