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Avalon Benefit Services – Claims
P.O. Box 1803
Dublin, OH 43017

IF CLAIM IS FOR HOSPITALIZATION AND/OR OTHER BENEFITS, PLEASE ATTACH ITEMIZED BILLS.

APPLICATION FOR BENEFITS

HOW TO PRESENT A CLAIM - PLEASE READ CAREFULLY

1. Both sides of this form should be completed - this side by the employee, the reverse side by the physician. A separate form is required for **each** family member submitting a claim. To avoid delay, answer all questions, sign and date the Patient's Authorization section.
2. If the physician or supplier does not complete the reverse side, attach itemized bills showing the following:
   Name, address and Tax ID Number of physician or provider of service
   Name of Patient
   Date(s) of service(s) rendered
   Charges(s) made
   Nature of illness or injury (Be certain your physician indicates the appropriate diagnosis code(s) from the current revision of the International Classification of Diseases, Clinical Modification (ICD - CM)
   Type of service(s) (Be certain your physician indicates the appropriate code from the most recent edition of the Current Procedural Terminology (CPT) or HCFA Common Procedural Coding System (HCPCS)
3. Please check all bills for accuracy. Do not present cancelled checks or cash register receipts as they do not contain the information needed to process a claim. Please follow the instructions in No. 2 above.
4. If you wish to retain copies of your bills, they should be retained before your claim is submitted.
5. If you or your dependent have received consideration of these expenses by another group plan, please attach a copy of your statements of payment or rejection from that plan.
6. If you or your dependent are eligible for Medicare, please attach a copy of your statements of payment or rejection for these expenses received from Medicare Part A and B.
7. Send the completed claim form, with bills attached, to the above address. If you have questions about your claim, you may call Avalon Benefit Services at 1-800-310-6645.

PART A-EMPLOYEE'S STATEMENT

ALL QUESTIONS MUST BE COMPLETED-FORM MUST BE DATED AND SIGNED

1. Employee's full NAME, Social Security Number and Date of Birth	First Initial Last		Employee's S.S. No.		Birth Date
2. Employee's Full Address	No. and Street		City	State	Zip
3. Is Claim for a Dependent? ☐ Yes ☐ No	Name of Dependent		Relationship	Birth Date	
4. If Student	Name of School		If dependent over the age of 18 - Please submit proof of attendance to an accredited school or college.		
5. Spouse's full NAME, Social Security	First Initial Last		Spouse's S.S. No.		Birth Date
6. A. Describe nature of ☐ Illness ☐ Injury			Date of onset:	Is this injury or illness related to any employment ☐ Yes ☐ No	
C. If an injury, state when, where and how injury occurred					
7. A. Are you married? ☐ Yes ☐ No B. If yes, is spouse employed? ☐ Yes ☐ No	Name and Address of Spouse's Employer				
8. Are you or your dependents covered under any other group medical benefit plan or governmental agency?	☐ Yes (Give Name, Address, and Policy No. in #9 below.) ☐ No				

9. Name and Address of the Other Insurance Company	Name of Employer, Group or School Providing the Plan	Name of the Insured Person	Policy Number (For Blue Cross, Give Certificate Number)

10. To all physicians and other health professionals, and all hospitals and other health care institutions:
You are authorized to provide Avalon Benefit Services and any subcontractors, consulting health professionals, utilization review organizations and insurance companies with whom ABS and/or the Plan has contracted, information concerning health care advice, treatment or supplies provided the Patient (including that related to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits. ABS may provide the employer named above with any benefit calculation used in payment of this claim for the purpose of reviewing the experience and operation of the Plan. This claim authorization is valid under the term of coverage of the Plan under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date: _____ Patient's or Authorized Person's Signature: _____

PART B — ATTENDING PHYSICIAN'S STATEMENT

PLEASE COMPLETE ALL ENTRIES

PATIENT & COVERED PERSON (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (First name, middle initial, last name)	2 PATIENT'S DATE OF BIRTH	3 COVERED PERSON'S NAME (First name, middle initial, last name)
4 PATIENT'S ADDRESS (Street, city, state, ZIP code)	5 PATIENT'S SEX MALE ☐ FEMALE	6 COVERED PERSON'S SOCIAL SECURITY NUMBER
	7 PATIENT'S RELATIONSHIP TO COVERED PERSON SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8 COVERED PERSON'S GROUP NAME
9 OTHER HEALTH COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10 WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ☐ NO B. AN AUTO ACCIDENT YES ☐ NO	11 COVERED PERSON'S ADDRESS (Street, city, state, ZIP code)
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I Authorize the Release of any Medical Information Necessary to Process this Claim SIGNED DATE		13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (Covered Person or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO
17 DATE PATIENT ABLE TO RETURN TO WORK	18 DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH
19 NAME OF REFERRING PHYSICIAN		20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO

23 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.

24 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

25 SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES ☐ NO	27 TOTAL CHARGE	28 AMOUNT PAID	29 BALANCE DUE
	30 YOUR SOCIAL SECURITY NO.	31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
32 SPECIALITY, IF ANY	33 YOUR EMPLOYER I.D. NO.	I.D. NO.		

*PLACE OF SERVICE CODES

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