GROUP RESOURCES INCORPORATED
P.O. Box 600999 * Dallas, TX 75360
(888) 474-8502

EMPLOYER GROUP NAME ______

EMPLOYER GROUP NUMBER ______

CLAIM FOR HEALTH CARE BENEFITS

1

Employee's Name (Please Print Full Name) | Sex

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally separated

First Name of Spouse

Employee's Birth Date | Group I.D. No.

Home Address: No. Street / City State Zip

Name and Address of Company where Spouse is Employed

Employee's Social Security Number

Spouse's Social Security Number

2

Patient's Name (if other than employee) | Date Covered | Relationship to Employee | If child—is (s)he married? ☐ Yes ☐ No | Patient's Birth Date

If child over 19, is (s)he dependent upon your maintenance and support? ☐ Yes ☐ No
Is (s)he a full time student? ☐ Yes ☐ No
If student, give name and location of school.

3

Date accident occurred or sickness began. | Description of injury or sickness.

If accident, where and how it occurred.

Was more than one family member involved in accident? ☐ Yes ☐ No If yes, give name(s).

Was illness or injury due, in any way, to the patient's occupation? ☐ Yes ☐ No
If "Yes," Explain

Was this an automobile accident? ☐ Yes ☐ No

4

Is Patient Covered by Another Plan?
Any Group Insurance, Blue Cross-Blue Shield or other prepayment arrangement maintained on a group basis? ☐ Yes ☐ No
Any other coverage provided by an employer or any federal, state, or other government agency? ☐ Yes ☐ No
If "Yes" please furnish name and address of employer, insurance company or governmental agency, type of coverage and policy number:

If eligible, is person enrolled in: Federal Medicare Part A ☐ Yes ☐ No — Effective Date of Part A is ______
Federal Medicare Part B ☐ Yes ☐ No — If Yes, Effective Date of Part B is ______

5

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any material false information or who conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime (In Florida a felony of the third degree).
I hereby certify that the above statements are correct.

Date ______ Signed ______
Employee's Signature

Employer's Name ______

IMPORTANT: THE FOLLOWING AUTHORIZATION MUST BE COMPLETED

To all physicians, hospitals, clinics, dispensaries, sanitoria, druggists, and all other agencies (including other insurance companies, Blue Cross-Blue Shield): You are authorized to permit Group Resources, Inc. or its representative to obtain or view a copy of your records pertaining to the examination, treatment, history, prescriptions and medical expenses of the patient identified above.

Such information may be used to the extent deemed necessary by Group Resources, Inc. to determine the value or amount payable on account of this claim for the patient identified above.

______ Patient's Signature/Parent if Patient is Minor

______ Date

PHYSICIAN'S STATEMENT

PATIENT INFORMATION

1. Patient's Name (First name, middle initial, last name)

2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I Authorize the Release of any Medical Information Necessary to Process this Claim.
SIGNED

3. I authorize payment of Medical Benefits to undersigned Physician or Supplier for services described below. This authorization is invalid unless Tax I.D. of provider is given below.
Signed (Covered or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

4. Date of — Illness (first symptoms) OR Injury (accident) OR Pregnancy (LMP)

5. Date first consulted you for this condition

6. Has patient ever had same or similar symptoms? ☐ Yes ☐ No

7. Date patient able to return to work

8. Dates of total disability — From — Through

9. Dates of partial disability — From — Through

10. Name of referring physician

11. For services related to hospitalization give hospitalization dates — Admitted: — Discharged:

12. Name & address of facility where services rendered (if other than home or office)

13. Was laboratory work performed outside your office? ☐ Yes ☐ No Charges:

14. Diagnosis or nature of illness or injury, relate diagnosis to procedure in COLUMN D by reference number 1, 2, 3, etc. or DX code.
Note: If possible please give CPT-4 procedure code in "C" below and ICD-9 in "D."
1.
2.
3.
4.

15. A Date of Service	B* Place of Service	C Procedure Code (Identify:)	Fully describe procedures, medical services or supplies furnished for each date given (Explain unusual services or circumstances)	D Diagnosis Code	E Charges	F

16. Signature of Physician or Supplier
Signed Date

17. Accept Assignment ☐ Yes ☐ No

18. Total Charge

19. Amount Paid

20. Balance Due

21. Physician Social Security No.

22. Physician's or Supplier's name, address, zip code & telephone number
I.D. No.

23. Your Patient's Account No.

24. Physician's Tax I.D. No.

*Place of Service Codes
1 — (IH) - Inpatient Hospital
2 — (OH) - Outpatient Hospital
3 — (O) - 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