# HOW TO FILE A MEDICAL CLAIM

**Claim payment may be delayed if information is incomplete or missing.**

Please note that HCFA and UB claim forms are available upon request from your provider.

**_____Part One – Attach itemized bills.**

Itemized bills are not balance due statements or Explanation of Benefits.

**Checklist to make sure all information required has been enclosed:**

- **_____ Doctor's name and address**
- **_____ Doctor's tax ID number**
- **_____ Patient's name**
- **_____ Diagnosis Code(s) ICD-9**
- **_____ Date of service**
- **_____ Charges/Cost of each treatment**
- **_____ Procedure Code(s) CPT-4**
- **_____ Place of service code**

**_____Part Two (Page 2) – to be complete signed and dated.**

To be completed by the Employee. Please note that employee signature, social security number, and authorization are required.

**_____Part Three – Keep a copy for your records.**

Mail your Medical claim form and itemized bills to:

**PAI, P.O. Box 6702 Columbia, South Carolina 29260**

**Questions?** Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.

# Medical Claim Form

**Send Medical Claims to: PAI, Attn: Claims,**
**PO Box 6702,**
**Columbia, SC 29260-6702**

**Attach itemized bills providing complete information on:**

- Doctor's name and address • Doctor's tax identification number • Patient's name • Diagnosis Code ICD-9 • Date of service
- Charges/Cost of each treatment • Procedure Codes CPT-4 • Place of service code

**Note:** Itemized bills are not balance due statements or Explanation of Benefits.

**Please note: Incomplete forms and the absence of itemized bills may delay the processing of your claim**

## Section 1: Employee Information

Employee's Name: _____ SSN: _____
Last First Middle

Address: _____
Street City State ZIP

Telephone: _____ Employer Name: _____ Group No. ( from ID card): _____

## Section 2: Patient Information

Patient's Name: _____
Last First Middle

SSN: _____ Birth Date: _____ Sex ☐ Male ☐ Female

Relationship to Employee: ☐ Self ☐ Spouse ☐ Daughter ☐ Son ☐ Other: (specify): _____

If the patient is your child and over 25, is he or she dependent upon you for support? ☐ Yes ☐ No

## Section 3: Claim Information

Is the claim for an ☐ accident ☐ illness Is treatment a result of occupational illness or injury? ☐ Yes ☐ No

When did the accident or illness occur? _____ First date consulted for the diagnosis? _____

Please explain what you were treated for, and if it was an accident, provide details on how, when, and where it happened. (Attach a separate sheet of paper to to this form if necessary.) _____

## Section 4: Authorization

**Instructions:** The authorization should be completed and signed by the insured. If the insured in unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To healthcare providers:

You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

_____ _____ _____
**Signed** **Date** **Relationship to insured if signed by other than insured**

(If signed by other than the Insured, please print name and address, and include guardianship papers or other evidence of legal representation.)

_____ _____
**Name** **Address**

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Underwritten by BCS Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, SC (Rev. 4-23-2019)

# Medical Claim Form

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**PO Box 6702,**
**Columbia, SC 29260-6702**

## Fraud Notices

**Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska**: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas, Louisiana, Rhode Island, West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California**: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Delaware**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia**: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Hawaii:** For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Idaho**: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

**Indiana**: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine, Tennessee, Virginia, Washington**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire**: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

**New Jersey**: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each violation.

**Ohio**: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Texas**: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**All Other States:** Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and/or civil penalties.

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