





MEDICAL CLAIM FORM

Follow These Steps to File Your Claim

1. Employee and Patient Information (Please print clearly & provide all information)			
Name of Club (Employer)			
Employee's Name (Last, First, Middle Initial)		Employee's Social Security Number: _____ - _____ - _____	
Employee's Home Address		Employee's Date of Birth: ____ / ____ / ____	
City	State	Zip Code	Employee's Marital Status: [] Married [] Single [] Divorced
Patient's Name (Last, First, Middle Initial)		Patient's Date of Birth: ____ / ____ / ____	
Patient's Relationship to Employee: [] Self [] Spouse [] Child [] Stepchild If age 19+ is child a full time student? [] Yes [] No If YES, provide name of school:		Is Patient covered by any other insurance plan? [] Yes [] No If YES, provide name and phone number of other insurance company: Effective date of other insurance: ____ / ____ / ____	
Is Spouse employed? [] Yes [] No If YES, provide name of employer:		Spouse's Date of Birth: ____ / ____ / ____	
2. Accident or Work-Related Injury Information (Complete items which apply to your claim.)			
Is claim due to an accident? [] Yes [] No If YES, where did injury occur?		Date of Injury: ____ / ____ / ____	
Describe injury:		Is this claim in any way work-related? [] Yes [] No	
3. Direct Payment Authorization (Complete only if you wish payment made directly to doctor, hospital, or other medical provider. NOTE: PPO Providers automatically receive direct payment.)			
Name of Doctor, Hospital, or Other Provider		Authorization for Direct Payment to Provider	
		 _____ Employee Signature Date	
4. Authorization to Release Medical & Insurance Information (Must be signed & dated by Employee.)			
I authorize any physician, hospital, or other medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me, my dependents, or our health, to disclose, whenever requested to do so by CTI Administrators Inc. or its representative, any and all such information. A photocopy of this authorization shall be considered as effective and valid as the original.			
I know it is a crime for any person to intentionally attempt to defraud or knowingly facilitate a fraud against an insurer by submitting an application or filing a claim containing a false or deceptive statement(s).			
 _____ Employee Signature Date			
5. ATTACH THE BILLS FOR THE MEDICAL EXPENSES YOU ARE CLAIMING. BILLS MUST BE ITEMIZED AND SHOW THE PATIENT'S NAME, DIAGNOSIS, TYPE OF TREATMENT AND DATE OF SERVICE.			

Please send the completed claim form and appropriate bills to:

CTI ADMINISTRATORS -- Claims Department

100 Court Avenue - Suite 306, Des Moines, IA 50309-2295

1-800-245-8813

OVER, PLEASE

FOR THE MEDICAL EXPENSES YOU ARE CLAIMING...

...Please have your physician or other provider complete this section
ONLY IF YOU ARE NOT attaching itemized bills, receipts, and statements of charges from all physicians, hospitals, pharmacies, or other providers of medical services.

PHYSICIAN OR PROVIDER INFORMATION ONLY (Patient & Insured Information on Front of Form)												
PLEASE TYPE OR PRINT CLEARLY												
Date of current illness (first symptom); or Injury (accident); or Pregnancy (LMP): ____/____/____			If Patient has had same or similar illness or injury, give first date ____/____/____			Dates patient unable to work in current occupation: From: ____/____/____ To: ____/____/____						
Name of referring physician or other source:			I.D. Number of referring physician			Hospitalization dates related to current services: From: ____/____/____ To: ____/____/____						
Diagnosis or nature of illness or injury: 1. _____ 3. _____ 2. _____ 4. _____						Outside Lab? [] Yes [] No			\$ Charges			
						Medicaid Resubmission Code			Original Ref. No.			
reserved for local use						Prior Authorization Number:						
Dates of Service		Place of Service	Type of Service	Procedures, Services, or Supplies (explain unusual circumstances) CPT/HCPCS Modifier	Diagnosis Code	\$ Charges	Days or Units	EPSDT Family Plan	EMG	COB	reserved for local use	
From	To											
____/____/____	____/____/____											
____/____/____	____/____/____											
____/____/____	____/____/____											
____/____/____	____/____/____											
____/____/____	____/____/____											
____/____/____	____/____/____											
____/____/____	____/____/____											
Tax I.D. Number [] SSN [] EID			Patient's Account Number			Accept Assignment? [] Yes [] No		Total Charges \$		Amount Paid \$		Balance Due \$
Signature of Physician or Provider, including degrees or credentials _____ signature _____ date			Name & Address of facility where services were rendered (if other than home or office)				Physician's/Provider's billing name, address, zip code, AND phone no. PIN # GRP #					