MUTUAL
HEALTH SERVICES℠

P.O. Box 4138 ♦ Akron, Ohio 44321
800-376-3762 ♦ Fax (330) 666-6685

Statement of Claim

PART A — EMPLOYEE MUST COMPLETE IN FULL

PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	PATIENT'S RELATIONSHIP TO INSURED	PATIENT'S SEX	PATIENT'S DATE OF BIRTH
	☐-Self ☐-Spouse ☐-Natural Child ☐-Other _____	☐ Male ☐ Female	/ /
EMPLOYEE NAME	EMPLOYEE'S HOME PHONE	SOCIAL SECURITY NUMBER	

ADDRESS (STREET, CITY, STATE, ZIP CODE)

IS CLAIM DUE TO INJURY OR ACCIDENT?	IF DUE TO INJURY OR ACCIDENT, DID IT OCCUR ON THE JOB?	DATE OF INJURY OR ACCIDENT
☐ Yes ☐ No	☐ Yes ☐ No	/ /

LOCATION	DESCRIBE BRIEFLY

IS PATIENT COVERED BY ANOTHER MEDICAL INSURANCE PLAN?	NAME, ADDRESS AND POLICY NO. OF INSURANCE CARRIER:
☐ Yes ☐ No	

SPOUSE'S EMPLOYER	ADDRESS (STREET, CITY, STATE, ZIP CODE)	SPOUSE'S SOCIAL SECURITY NUMBER

TO BE COMPLETED AND SIGNED BY THE EMPLOYEE IF DIRECT PAYMENT OF BENEFITS TO THE PHYSICIAN OR SURGEON IS DESIRED.
NOTE: ONCE BENEFITS ARE ASSIGNED, THE ASSIGNMENT CANNOT BE REVOKED

I authorize payment to be made directly to the provider.

Signature of Eligible Person _____ Date

AUTHORIZATION

1. I hereby authorize any hospital, physician, or other person who has attended or examined me to furnish to Benefit Services all information with respect to this illness or accident, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records and permit the review, copying or photocopying of such records. A photocopy or fax of this authorization shall be considered as effective and valid as the original. If claim is on spouse, both husband and wife must sign.
2. Any person who, knowingly and with intent to deceive, files a statement of claim containing any materially false or misleading information is guilty of a crime. Please review this form thoroughly. Make certain all information is accurate and complete. Errors or omissions can result in payment delays or forfeiture of benefits. I certify that the information on this form is accurate and complete to the best of my knowledge.

Employee Signature _____ Date

PART B — TO BE COMPLETED BY PROVIDER OR SUPPLIER

PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)	PATIENT'S RELATIONSHIP TO INSURED	PATIENT'S SEX	PATIENT'S DATE OF BIRTH
	☐ Self ☐ Spouse ☐ Natural Child ☐ Other _____	☐ M ☐ F	/ /
PATIENT'S ADDRESS	CITY, STATE, ZIP		

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

DATE OF SERVICE	PLACE OF SERVICE	FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN Proc. Code (Identify) (Explain unusual services or circumstances)	DX CODE	CHARGES	WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT
					Yes ____ No ____ AN ACCIDENT? Yes ____ No ____ DATE PATIENT FIRST SEEN FOR THIS CONDITION:

	TOTAL CHARGES	AMT. PAID	BALANCE

PHYSICIAN OR SUPPLIER NAME	ADDRESS, CITY, STATE, ZIP	PHONE

YOUR PATIENT ACCOUNT NO.	INDIVIDUAL PRACTITIONER - SOCIAL SECURITY NUMBER:	
	ALL OTHERS - EMPLOYER I.D. NUMBER:	

SIGNATURE OF PHYSICIAN OR SUPPLIER

Signed _____ Date

1/13/13