



Send All Medical Claims to:
Allied Benefit Systems, Inc.
P.O. Box 909786-60690
Chicago, IL 60690

Phone Numbers:
Tel: 312-906-8080
Fax: 312-906-8359
Toll Free: 800-288-2078*

*Outside IL

MEDICAL CLAIM FORM

INSTRUCTIONS: Complete the form below. Please see the reverse side for more detailed instructions.

Return the completed form to Allied Benefit Systems

EMPLOYEE'S STATEMENT OF CLAIM FOR GROUP HEALTH BENEFITS			
1. CLAIM IS BEING MADE FOR: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Unmarried Child _____ <div style="text-align: right;"><input type="checkbox"/> Other</div>			
2. PATIENT'S NAME:		DATE OF BIRTH: / /	
		SEX:	
3. IS THIS CLAIM DUE TO AN ACCIDENT? IF YES, WHERE DID ACCIDENT OCCUR? DATE OF ACCIDENT: / / <input type="checkbox"/> Yes <input type="checkbox"/> No DESCRIBE ACCIDENT:			
4. IS THIS CLAIM AS A RESULT OF A WORK RELATED ILLNESS OR INJURY? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. ARE YOU (Employee) MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", PLEASE PROVIDE:		IF CLAIM IS FOR A DEPENDENT CHILD, IS YOUR CHILD EMPLOYED? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", PLEASE PROVIDE:	
_____ NAME OF SPOUSE		_____ NAME OF DEPENDENT	
_____ EMPLOYER OF SPOUSE		_____ EMPLOYER OF DEPENDENT	
_____ ADDRESS OF EMPLOYER		_____ ADDRESS OF EMPLOYER	
6. IS THE PATIENT COVERED UNDER ANY OTHER PLAN PROVIDING HEALTH BENEFITS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF "YES", PROVIDE THE NAME AND ADDRESS OF THE COMPANY OR INSURANCE CARRIER PROVIDING BENEFITS:			
_____ NAME OF COMPANY OF INSURANCE CARRIER		_____ (Area) TELEPHONE NUMBER	
_____ STREET NUMBER		_____ CITY STATE ZIP	
7. _____ EMPLOYEE'S NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER (Area) TELEPHONE NUMBER _____ STREET NUMBER CITY STATE ZIP			
8. AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the foregoing statements are true and correct to the best of my knowledge. I also authorize any hospital, physician, or other persons who have attended me or examined me or any of my dependents, to disclose to Allied Benefit Systems, Inc. and/or my employer any and all information with respect to any illness or injury, medical history, consultation, diagnosis or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.			
		_____ PATIENT'S SIGNATURE DATE (If other than Employee, omit if patient is a minor.)	
		_____ EMPLOYEE'S SIGNATURE DATE	
9. ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to the provider of medical services which are otherwise payable to me for services rendered. Payment will be made in accordance with the provisions of the benefit plan.			
		_____ EMPLOYEE'S SIGNATURE DATE	
10. North Suburban Library System A01195 NAME OF EMPLOYER GROUP NO. Telephone Number _____ STREET NUMBER CITY STATE ZIP			

INSTRUCTIONS FOR FILING A CLAIM

COMPLETE EMPLOYEE'S STATEMENT: PLEASE BE SURE TO ANSWER EVERY QUESTION.

All bills must show patient's name, date(s) of treatment, nature of treatment (diagnosis) and fee for each service.

If a claim is for prescription drugs, attach bills to form after completing "Employee's Statement of Claim" section. All bills must show: patient's name; prescription number; date(s) of purchase; and charge.

If claim is for registered nurses, x-ray, laboratory or medical equipment, attach bills to the form after completing "Employee's Statement of Claim" section. All bills must show: patient's name; nature and date(s) of service; amount of charge; and prescribing physician. Additional data will be requested if needed.

This list follows the numerical order on the claim form:

- 1.) *Check the appropriate box for whom the claim is being made.*
- 2.) *Provide the patient's name, date of birth, and sex.*
- 3.) *Check the appropriate box (yes or no) if the claim is due to an accident. State where the accident occurred and the date of the accident. Please provide a brief description of the accident.*
- 4.) *Check the appropriate box (yes or no) if the claim is work related.*
- 5.) *Check the appropriate box(es) if the employee is married and if the spouse is employed. Provide the employer's name and address.*
 - a.) *If the claim is for a dependent child, check the appropriate box if the child is employed. Provide the employer's name and address.*
- 6.) *If the patient is eligible for benefits under another plan, please check the appropriate box and provide the name and address of the insurance carrier or company providing the other benefits for the patient.*
- 7.) *Provide the employee's name and address.*
- 8.) *Sign and date the claim form.*
- 9.) *Sign and date the Assignment of Benefits, if applicable.*
- 10.) *Provide the employer's name and address.*

Mail the claim form and the itemized bill to Allied Benefit Systems, Inc. P.O. Box 909786-60690, Chicago, IL 60690. KEEP A COPY FOR YOUR RECORDS.

IMPORTANT ITEMS TO NOTE

- 1.) All charges must be submitted within the time frame specified in the summary plan description. Failure to do so will result in the denial of the charges.
- 2.) From time to time, additional information may be requested in order to process a claim. Any additional information, i.e., other insurance payments, completed claim forms, subrogation forms, accident details, police reports, etc., must be submitted when requested. Failure to do so may result in the denial of the claim.
- 3.) ALWAYS retain a copy for your records.