

Fletcher Allen Preferred Medical Plan Medical Care Claim Form

Vermont Managed Care, Inc.
C/O Apex Benefits Services
PO Box 3620
Akron, OH 44309-3620

DO NOT USE STAPLES

Provider Section, Instructions and Mailing Information on Reverse side

EMPLOYEE INFORMATION: Employee Complete This Section			
A. Employee Name (First, MI, Last)		B. Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
C. Employee's Mailing Address (Street, City, State, Zip)			Daytime Phone # (with area code)
Is This a Change of Address? <input type="checkbox"/> Yes <input type="checkbox"/> No	E. Employee's Identification Number	F. Marital Status	G. Group Number
H. Employer		I. Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Cobra <input type="checkbox"/> Retired	
PATIENT INFORMATION: Complete only if Patient is Other Than Employee			
A. Patient's Name (First, MI, Last)		B. Relationship to Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	C. Date of Birth
D. Complete this information if patient is an unmarried dependent child		F. Name, Address and Phone # of Child's School / Employer	
Dependent Child is: <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Student Full-Time		D. Sex <input type="checkbox"/> M <input type="checkbox"/> F	
ACCIDENT/OCCUPATIONAL CLAIM INFORMATION: Complete only if claim is a result of an accident or occupational illness or injury			
A. Description of Illness (How, When, Where)			B. Illness/Injury due to Employment <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Date of Beginning of Illness/Injury	D. Injury due to Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	E. Have You or Your Dependent, or will you or your Dependent File Claim for Worker's Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
F. Are You or Your Dependents Filing a Claim or Lawsuit Against a Third Party in Order to Recover the Cost of Expenses Incurred as a Result of this Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
FAMILY/OTHER COVERAGE INFORMATION: Complete Only if Claim is for a Dependent and/or Other Coverage is in Effect			
A. Spouse Employed <input type="checkbox"/> Yes <input type="checkbox"/> No		C. Spouse's Date of Birth	
If No, Has Spouse Been Employed During Last 12 Months? <input type="checkbox"/> Yes <input type="checkbox"/> No		B. Name of Spouse (First, MI, Last)	
D. Spouse's Social Security #	E. Name, Address and Phone # of Spouse's Employer		
F. Is the Patient Covered Under Another Group Insurance or Government Plan Such as Medicare, an HMO Plan or Automobile Mandatory No-Fault Coverage Which Will Also Cover Any of the Medical Expenses or Disability Losses of this Claim? If Yes, Give Name and Address of Insurance Company, Organization, or HMO Providing Benefits			Policy #:
Name & Address			
EMPLOYEE'S / PATIENT'S SIGNATURE AND RELEASE: Employee Must Sign all Claims			
A. AUTHORIZATION TO RELEASE INFORMATION – I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable, including disability or employment related information, to Employer's Mutual Inc., Vermont Managed Care, or their authorized agents for the purpose of validating and determining benefits payable. I will receive a copy of this authorization upon request. This authorization or a copy shall be valid for one year from the date of signature. If the information disclosed relates to substance abuse treatment, Federal Law protects these records' confidentiality. Federal regulations (42CFR Part 2) prohibit making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect confidentiality of patient's records.			
Patient's Signature (Parent or Guardian if Claim is on a Minor)			Date:
Note: If you wish your benefits paid directly to the physician or provider of service, sign in box B, below. Benefits will be paid directly to the hospital or hospital confinement.			
B. PAYMENT AUTHORIZATION – I authorize payment directly to those health care providers described below, and/or as indicated on the enclosed bills, of medical benefits otherwise payable to me, for services rendered by them.		If Yes, Employee's Signature	Date

