BENEFIT REQUEST FORM
TYPE OR PRINT

Submit To: Key Benefit Administrators, Inc.
P.O. Box 2050
Fort Mill, SC 27916-2050

KEY BENEFIT ADMINISTRATORS, INC.

PATIENT INFORMATION (TO BE COMPLETED BY EMPLOYEE)

1. PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME AND ADDRESS
FULL TIME STUDENT ☐ YES ☐ NO IF YES, WHERE		
4. PATIENT'S ADDRESS *(if different from employee)*	5. PATIENT'S SEX ☐ MALE ☐ FEMALE	6. EMPLOYEE'S SOC. SEC. NO.
	7. PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	8. GROUP NAME *(e.g. employer)*
9. OTHER HEALTH INSURANCE COVERAGE ☐ YES ☐ NO If yes, Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B AN ACCIDENT ☐ YES ☐ NO	11. IF AN ACCIDENT ☐ AM date_____20_____and time_____ ☐ PM description (how & where) _____

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *I authorize the Release of any Medical Information Necessary to Process this request.* SIGNED: DATE:	13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.* *SIGNED (Employee or Authorized Person)*

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO EMPLOYEE)

14. DATE OF: ◀	**ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)**	**15. DATE FIRST CONSULTED YOU FOR THIS CONDITION**	**16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?** ☐ **YES** ☐ **NO**

17. DATE PATIENT ABLE TO RETURN TO WORK	**18. DATES OF TOTAL DISABILITY**		**DATES OF PARTIAL DISABILITY**	
	FROM	**THROUGH**	**FROM**	**THROUGH**

19. NAME OF REFERRING PHYSICIAN	**20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES**	
	ADMITTED	**DISCHARGED**

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)	**22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?** ☐ **YES** ☐ **NO**	**CHARGES:**

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

1.
2.
3.
4.

24. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D DIAGNOSIS CODE	E CHARGES	F
		PROCEDURE CODE (IDENTIFY:)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*			

25. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	26.	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
	30. YOUR SOC. SEC. NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER ID NO			

*PLACE OF SERVICE CODES
1-(IH)-INPATIENT HOSPITAL
2-(OH)-OUTPATIENT HOSPITAL
3-(O)-DOCTOR'S OFFICE
4-(H)-PATIENT'S HOME
5- DAYCARE FACILITY (PSY)
6- NIGHT CARE FACILITY (PSY)
7-(NH)-NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9- AMBULANCE
O-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B- OTHER MEDICAL/SURGICAL FACILITY

***PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY**