CITY OF RENTON

Send claims to: Healthcare Management Administrators, Inc.
P.O. Box 85008, Bellevue, WA 98015
Toll Free (800) 869-7093 Local (425) 462-1000

MEDICAL CLAIM FORM

PART 1: Employee Information

EMPLOYEE NAME (Last and First)	EMPLOYEE DATE OF BIRTH MONTH DAY YEAR	EMPLOYEE SOCIAL SECURITY # ___ ___	GROUP # 4034

EMPLOYEE ADDRESS CITY STATE ZIP

IS THIS AN ADDRESS CHANGE? ☐ YES ☐ NO

EMPLOYEE'S TELEPHONE NUMBER

☐ SINGLE ☐ MARRIED _____ ☐ WIDOWED ☐ LEGALLY SEPARATED ☐ DIVORCED
NAME OF SPOUSE

IF DIVORCED & CLAIM IS FOR DEPENDENT CHILD, ANSWER THE FOLLOWING QUESTIONS: A) IS THIS CHILD IN YOUR PERMANENT CUSTODY? ☐ YES ☐ NO

B) IS THERE A COURT ORDER FOR PROVISION OF MEDICAL CARE FOR THIS CHILD? ☐ YES ☐ NO

PART 2: Patient Information

PATIENT NAME

MARITAL STATUS

IS PATIENT ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD ☐ OTHER

IF OTHER, SPECIFY _____

PATIENT DATE OF BIRTH MONTH DAY YEAR

IF CLAIM IS FOR DEPENDENT OVER AGE 19, IS THE DEPENDENT A FULL TIME STUDENT?

IF SO, PLEASE PROVIDE PROOF OF STUDENT STATUS.

PART 3: Description of Claim

DESCRIBE ILLNESS OR INJURY:

WORK RELATED ILLNESS OR INJURY: ☐ YES ☐ NO

IF YES, DID YOU OR WILL YOU BE FILING A CLAIM WITH L&I? ☐ YES ☐ NO

IF CLAIM IS DUE TO ACCIDENT STATE WHEN, WHERE AND HOW THE ACCIDENT OCCURRED:

HAS PATIENT BEEN TREATED FOR THIS ILLNESS OR INJURY WITHIN THE PAST 12 MONTHS?

☐ YES ☐ NO IF YES, DATE OF SERVICE: _____

IF YES, NAME AND ADDRESS OF ATTENDING PHYSICIAN

REFERRING PHYSICIAN IF APPLICABLE _____

PART 4: Other Group Health Insurance

ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED BY OTHER INSURANCE FOR MEDICAL, DENTAL, OR VISION BENEFITS? ☐ YES ☐ NO

CHECK ONLY THOSE COVERED BY OTHER GROUP INSURANCE:

☐ SELF ☐ SPOUSE DATE OF BIRTH _____ ☐ DEPENDENT(S)

LIST THE DEPS. _____

NAME AND ADDRESS OF OTHER INSURANCE CARRIER:

POLICY NUMBER: _____

EFFECTIVE DATE: _____

IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS?

☐ YES ☐ NO IF YES, ENTER DATE OF ELIGIBILITY _____ SOCIAL SECURITY NO. _____

PART 5: Complete for all

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING FALSE INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

EMPLOYEE SIGNATURE _____ DATE _____

PART 6: Claims Benefit Assignment and Authorization

SIGNED (BY EMPLOYEE)

I AUTHORIZE PAYMENT OR BENEFITS DIRECTLY TO THE PHYSICIAN OR SUPPLIER: _____ DATE _____

AUTHORIZATION TO RELEASE INFORMATION: I expressly authorize any provider of care to furnish HMA, any records concerning me or any Member of my family for whom benefits or services has been claimed.

SIGNED (BY PATIENT, OR PARENT, IF MINOR)

_____ DATE _____