



BENEFIT PLANS

ABDI Benefit Plans  
P. O. Box 2146  
Springfield, IL 62705

**STATEMENT of MEDICAL CLAIM  
GROUP HEALTH BENEFITS**

HOW TO COMPLETE THIS FORM

1. Answer all appropriate questions in Section I and II
2. Take form to your doctor for completion of Section III, if applicable
3. Return form to ABDI Benefit Plans when completed

SECTION I: TO BE COMPLETED BY THE EMPLOYEE

1. Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M  F

2. Home Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Street City

3. Social Security No. \_\_\_\_\_ Occupation \_\_\_\_\_

4. Employer \_\_\_\_\_

5. Is this claim for a dependent? Yes  No

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Married Yes  No

Date of Birth \_\_\_\_\_ Full time Student Yes  No  High School  Trade

University/College  \_\_\_\_\_

6. Nature of Illness \_\_\_\_\_

Date of First Treatment for this Illness \_\_\_\_\_

7. Name & Address of Doctor Seen for this Illness \_\_\_\_\_  
\_\_\_\_\_

8. Is this claim based on an accident: Yes  No

If yes, give date \_\_\_\_\_ & Time \_\_\_\_\_ a.m.  p.m.

Where did the accident occur? \_\_\_\_\_

Give a brief description of the accident \_\_\_\_\_  
\_\_\_\_\_

9. Is this claim work related? Yes  No

*I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the above information in support of this claim is true and correct.*

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE NOTE: Benefits payable under this policy will be paid according to a schedule of Reasonable & Customary charges. Excessive charges will be disallowed.**

**ASSIGNMENT OF BENEFITS**

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SECTION II: TO BE COMPLETED BY EMPLOYEE

Date \_\_\_\_\_

*I hereby authorize payment to (PRINT – Name of Physician) \_\_\_\_\_ for the surgical benefits otherwise payable to me but not to exceed the charges stated previously. I understand I am financially responsible to the physician for the charges not covered by this authorization.*

Sign here to pay Physician \_\_\_\_\_ Date \_\_\_\_\_

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**ATTENDING PHYSICIAN'S STATEMENT**

SECTION III: TO BE COMPLETED BY ATTENDING PHYSICIAN

Diagnosis and Concurrent Conditions

Is Condition due to injury or sickness arising out of patient's Employment? YES  NO  If yes, explain

Is Condition due to pregnancy? If yes, what was approximate date of commencement of pregnancy? YES  NO  Date \_\_\_\_\_

Nature of surgical or obstetrical procedure, if any. (Describe fully)

Date performed \_\_\_\_\_

Charge to patient for this procedure include post-operative care \$ \_\_\_\_\_

Inpatient  Outpatient  If performed in hospital, give name of hospital \_\_\_\_\_

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Give dates of other medical (non-surgical) treatment, if any.

Charge per call

Office \_\_\_\_\_ \$ \_\_\_\_\_

Home \_\_\_\_\_ \$ \_\_\_\_\_

Hospital \_\_\_\_\_ \$ \_\_\_\_\_

Total (non-surgical) charges \$ \_\_\_\_\_

What other services, if any, did you provide patient? (Itemize giving dates)

Is patient still under your care for this condition? YES  NO  Date \_\_\_\_\_  
If no, give date your services terminated.

Have you previously treated the patient for this condition? YES  NO  Date \_\_\_\_\_  
If yes, when?

How long was or will patient be continuously totally disabled (unable to work)? From \_\_\_\_\_ 2 \_\_\_\_\_ through \_\_\_\_\_ 2 \_\_\_\_\_

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Date \_\_\_\_\_ Physician's Name (PRINT or TYPE) \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Physician's Tax I.D. \_\_\_\_\_

Address (PRINT or TYPE) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I WILL NOT ACCEPT THIS ASSIGNMENT

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