Application for Benefits

AULTCARE

MAIL TO:
AultCare
P.O. Box 6910
Canton, Ohio 44706-0910

Place of Employment	Group Number

EMPLOYEE STATEMENT

Each family member must complete one form annually at each physician office. ☐ ACTIVE ☐ RETIRED ☐ SALARIED ☐ HOURLY

PATIENT & EMPLOYEE INFORMATION

1. PATIENT'S NAME (First Name, Middle Initial, Last Name)	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE NAME (First Name, Middle Name, Last Name)
4. PATIENT'S ADDRESS (Street, City, State, ZIP code) PHONE #	5. PATIENT'S SEX ☐ MALE ☐ FEMALE 7. PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	6. EMPLOYEE ADDRESS (Street, City, State, ZIP code) 8. MARITAL STATUS: SINGLE ☐ SEPARATED ☐ DIVORCED ☐ MARRIED ☐ WIDOWED ☐
9. ARE YOU OR ANY OF YOUR DEPENDENTS EMPLOYED ELSEWHERE? ☐ Yes ☐ No If yes where Phone		10. EMPLOYEE I.D. NO. (Soc. Sec. No.)
11. OTHER GROUP HEALTH COVERAGE – Enter name of Policyholder and Plan Name and Address and Policy Number		12. WAS CONDITION RELATED TO A. Patient's employment ☐ yes ☐ no B. An Auto accident ☐ yes ☐ no Date/Description/Location of Accident
13. IS PATIENT A FULLTIME STUDENT? ☐ Yes ☐ No If yes where? School: _____ Expected Date of Graduation City: _____		14. IF ELIGIBLE, IS PERSON ENROLLED IN: Federal Medicare Part A ☐ Yes ☐ No Federal Medicare Part B ☐ Yes ☐ No Effective Date of Part A is _____ If Yes, Effective Date of Part B is _____
15. ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, OR PHARMACIST TO RELEASE ANY INFORMATION REQUESTED WITH REGARD TO THIS CLAIM AND THE EXPENSES REPORTED. Signed (Patient or Authorized Person) Date		16. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. Signed (Employee or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION *(If Patient Completes, Must Attach Itemized Receipts)*

17. DATE OF ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	18. DATE FIRST CONSULTED YOU FOR THIS CONDITION	19. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ Yes ☐ No
20. DATE PATIENT ABLE TO RETURN TO WORK	21. DATES OF TOTAL DISABILITY From Through	DATES OF PARTIAL DISABILITY From Through
22. NAME OF REFERRING PHYSICIAN		23. FOR SERVICES RELATED TO HOSPITALIZATION GIVE DATES Admitted Discharged
24. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If Other Than Home or Office)		25. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ Yes ☐ No Charges

26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

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

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements attached apply to this bill and are made a part hereof) SIGNED DATE	29. ACCEPT ASSIGNMENT ☐ Yes ☐ NO	30. TOTAL CHARGE	31. AMOUNT PAID	32. BALANCE DUE
35. YOUR PATIENT'S ACCOUNT NUMBER	33. YOUR SOCIAL SECURITY NUMBER 36. YOUR EMPLOYER I.D. NO.	34. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. I.D. NO.		

PLACE OF SERVICE CODES

(IH) - INPATIENT HOSPITAL	4-(H) - PATIENT'S HOME	7-(NH) - NURSING HOME	O-(OL) - OTHER LOCATIONS
(OH) - OUTPATIENT HOSPITAL	5 - DAY CARE FACILITY (PSY)	8-(SNF) - SKILLED NURSING FACILITY	A-(IL) - INDEPENDENT LABORATORY
(O) - DOCTORS OFFICE	6 - NIGHT CARE FACILITY (PSY)	9 - AMBULANCE	B - OTHER MEDICAL/SURGICAL FACILITY