

## TO BE COMPLETED BY EMPLOYEE

INFORMATION ON SPOUSE AND/OR DEPENDENTS MUST BE COMPLETED IN FULL BEFORE A CLAIM WILL BE PROCESSED								
1	EMPLOYER'S NAME				GROUP#			
	EMPLOYEE MVP I.D. NO			EM	EMPLOYEE'S SOCIAL SECURITY NUMBER			
2	NAME OF EMPLOYEE		ARRIED □ DIVORCED  NGLE □ SEPARATED	BIR	THDATE	□ FEMALE □ MALE	TELEPHONE NO.	
3	ADDRESS OF EMPLOYEE – NUMBER AND STREET CITY			ST	ATE	ZIP CODE	☐ ACTIVE☐ RETIRED	
4	NAME OF PATIENT		PLAN ID#	BIR	THDATE	□ FEMALE □ MALE	RELATIONSHIP	
5	EMPLOYER (IF ANY) OF SPOUSE OR DEPENDENT CHILD							
6	IF STUDENT, NAME OF SCHOOL PRESENTLY ATTENDING CITY STATE ZIP CODE TELEPHONE NO.  ( )							
7	IS PATIENT ELIGIBLE FOR MEDICARE?  ☐ YES ☐ NO					S PATIENT FULL-TIME STUDENT OVER AGE 18?		
8	DO YOU OR ANY OF YOUR FAMILY MEMBERS HAVE OTHER HEALTH INSURANCE?		IF YES:  (A) INSURANCE COMPANY  (B) EMPLOYER (NAME AND ADDRESS)  (C) POLICY OR I.D. NUMBER					
9	NATURE OF ILLNESS							
10	IS CLAIM BASED ON ACCIDENT? DID ACCIDENT HAPPEN WHILE WORKING? A  □ YES □ NO □ YES □ NO □				TO ACCIDENT? OTHER DATE AND TIME OF ACCIDEN			
11	DESCRIPTION OF ACCIDENT (HOW AND WHERE)							
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.								
ASSIGNMENT: I hereby authorize payment directly to the hospital, physician or dentist herein named. I understand I am financially responsible for charges not covered by this assignment.								
Employee Signature ▶ Date signed ▶								
AUTHORIZATION TO RELEASE: I hereby authorize MVP to release or obtain any information which may be necessary to administer this Group Plan. A photocopy of this authorization shall be valid.								
Employee Signature ▶					Date signed ▶			
Patient Signature ▶ Date signed ▶								
(Parent should sign for minor child)								

## Are itemized bills enclosed?

An itemized bill is one that shows the patient's name, relationship, date of service, the type of service rendered, and the nature of the condition being treated.

If any information is missing, please write it on the bill yourself and sign your name.

## **MVP Health Care**