

# PART A — EMPLOYEE STATEMENT

NAME OF EMPLOYER: \_\_\_\_\_

1. NAME OF PATIENT _____	2. PATIENT DATE OF BIRTH / / _____	3. INSURED EMPLOYEE'S NAME _____
4. PATIENT ADDRESS (STREET, CITY, STATE ZIP CODE) _____ _____	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. EMPLOYEE SOCIAL SECURITY NO. _____
	7. PATIENT RELATIONSHIP SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>
9. INSURED'S ADDRESS AND TELEPHONE NUMBER _____ _____		10. WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>  AN AUTOMOBILE ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>

11. NOTE TO EMPLOYEE: PLEASE PROVIDE THE FOLLOWING INFORMATION WITH REGARD TO YOUR SPOUSE:

NAME \_\_\_\_\_ DATE OF BIRTH / / \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

EMPLOYER'S NAME AND ADDRESS \_\_\_\_\_ TELEPHONE NUMBER ( ) \_\_\_\_\_

12. ARE YOU, YOUR SPOUSE OR DEPENDENTS COVERED BY ANY OTHER GROUP INSURANCE, STUDENT INSURANCE, PREPAID HEALTH PLAN, MEDICARE OR OTHER GOVERNMENT PLAN? YES  NO  IF YES, PLEASE COMPLETE THE FOLLOWING:

INSURED'S NAME \_\_\_\_\_ GROUP INSURANCE COMPANY OR PLAN NAME \_\_\_\_\_

GROUP POLICY NUMBER \_\_\_\_\_ CERTIFICATE NUMBER \_\_\_\_\_

GROUP INSURANCE PLAN ADDRESS AND TELEPHONE NUMBER \_\_\_\_\_

13. IF CLAIM FOR DEPENDENT CHILDREN, ARE NATURAL PARENTS DIVORCED OR SEPARATED? YES  NO

14. DOES NATURAL PARENT WITHOUT CUSTODY HAVE FINANCIAL RESPONSIBILITY FOR HEALTH CARE? YES  NO

15. COMPLETE THE FOLLOWING IF CLAIM IS RELATED TO INJURY:

DATE INJURY OCCURRED \_\_\_\_\_ DATE FIRST TREATED \_\_\_\_\_

WHERE AND HOW DID THE INJURY HAPPEN? \_\_\_\_\_

**NOTICE TO ALL COMPLETING THIS FORM**  
IT IS FRAUDULENT TO FILL OUT THIS FORM WITH INFORMATION YOU KNOW TO BE FALSE OR TO OMIT INFORMATION WHICH YOU KNOW TO BE FACT. I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREON ARE COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

17. AUTHORIZATION: I HEREBY AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE OR ANY PERSON OR ORGANIZATION IN POSSESSION OF INSURANCE OR OTHER BENEFIT INFORMATION CONCERNING ME OR MY DEPENDENTS TO FURNISH TO GRAPHIC ARTS BENEFIT CORPORATION FULL INFORMATION REGARDING SUCH CARE, INSURANCE OR ANY OTHER BENEFIT INFORMATION NECESSARY IN PROCESSING THIS CLAIM.  
FURNISH SIGNATURE (SIGNATURE OF SPOUSE IS NOT ACCEPTABLE) \_\_\_\_\_ DATE \_\_\_\_\_

18. I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER OF MEDICAL SERVICE FOR WHICH THIS CLAIM IS MADE. SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

# PART B — PHYSICIAN OR SUPPLIER INFORMATION

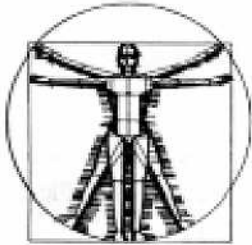
1. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	2. DATE FIRST CONSULTED YOU FOR THIS CONDITION	3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
4. DATE PATIENT ABLE TO RETURN TO WORK	5. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____
6. NAME OF REFERRING PHYSICIAN _____		7. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____
8. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office) _____		9. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES _____
10. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATED DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE _____		

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

12. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED _____	13. TOTAL CHARGE	14. AMOUNT PAID	15. BALANCE DUE
DATE _____	17. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NUMBER		
18. YOUR PATIENT'S ACCOUNT NO.	18. YOUR SOCIAL SECURITY NO.	19. YOUR EMPLOYER I.D. NO.	

**PLACE OF SERVICE CODES**

1 - (IH) - INPATIENT HOSPITAL	4 - (H) - PATIENT'S HOME	7 - (NH) - NURSING HOME	0 - (OL) - OTHER LOCATIONS
2 - (OH) - OUTPATIENT HOSPITAL	5 - DAY CARE FACILITY (PSY)	8 - (SNF) - SKILLED NURSING FACILITY	A - (IL) - INDEPENDENT LABORATORY
3 - (C) - DOCTOR'S OFFICE	6 - NIGHT CARE FACILITY (PRY)	9 - AMBUULANCE	R - OTHER MEDICAL/SURGICAL FACILITY



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**GRAPHIC ARTS BENEFIT CORPORATION  
HOW TO FILE A CLAIM FOR BENEFITS**

- STEP 1 EMPLOYEE STATEMENT MUST BE COMPLETED FOR ALL CLAIMS SUBMITTED.**
- STEP 2 IF CLAIM IS THE RESULT OF INJURY, INFORMATION REQUESTED IN QUESTION 15 OF EMPLOYEE STATEMENT MUST BE SUPPLIED.**
- STEP 3 FOR INITIAL CLAIM, REFER FORM TO YOUR ATTENDING PHYSICIAN TO HAVE THE ATTENDING PHYSICIAN'S STATEMENT COMPLETED BEFORE SUBMITTING.**
- STEP 4 FOR ONGOING CLAIMS, COMPLETE ONLY THE EMPLOYEE STATEMENT AND FORWARD.**
- STEP 5 ATTACH ITEMIZED STATEMENTS (ORIGINAL BILLS ONLY) TO THE CLAIM FORM AND MAIL.**
- STEP 6 PPO PROVIDERS SHOULD CONTACT THE GRAPHIC ARTS BENEFIT CORPORATION FOR INFORMATION ON FILING PROCEDURES, IF NECESSARY, OR FOR BENEFIT VERIFICATION.**