

# INSURANCE CLAIM FORM

1. INSURED'S ID NUMBER		1 b. INSURED'S SSN	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE GENDER MM DO YY M F / /	
4. INSURED'S NAME (Last Name, First Name, MI)		5. PATIENT'S ADDRESS (No, Street)	
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		7. INSURED'S ADDRESS (No, Street)	
CITY	STATE	CITY	STATE
ZIP CODE	TELEPHONE (INC. AREA CODE)	ZIP CODE	TELEPHONE (INC. AREA CODE)
8. PATIENT STATUS Single Married Employee Other		9. OTHER INSURED'S NAME (Last Name, First Name, MI)	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) Yes No b. AUTO ACCIDENT? Yes No c. OTHER ACCIDENT? Yes No		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH GENDER MM DO YY M F / /	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DO YY M F / /		b. EMPLOYERS NAME	
c. EMPLOYER'S NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes No	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of my medical or other information necessary to process this claim.  Signed _____ Date _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to be sent to the physician or supplier for services as attached.  Signed _____ Date _____	

**Please attach all itemized receipts and send to:**

Consociate Health Customer Service  
customerservice@consociate.com  
**Phone:** 800-798-2422 **Fax:** 217-423-4575

Consociate Health  
PO Box 1068  
Decatur, IL 62525