

## CLAIM STATEMENT

### PART 1

**PLEASE ATTACH ALL BILLS TO THIS FORM**

Name of Policyholder:			
Address:		City:	State: Zip:
Telephone Number - Day:	Evening:	Fax Number:	
Policy Number:	Patient's Name (if a dependent):		Dependent's Date of Birth:
Does the patient have any other health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF YES, COMPLETE THE FOLLOWING:</b>			
Employer/Policyholder:			
Policy Number:		Effective Date:	
Name of Other Insurance Company:			<input type="checkbox"/> GROUP or <input type="checkbox"/> INDIVIDUAL
Are you receiving or applying for Worker's Compensation or other disability benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO			

#### COMPLETE THIS SECTION IF CLAIM IS DUE TO ILLNESS

Date Illness Began:	Date of First Treatment:	Treated by Whom/Where:
Describe illness and any prior treatment for similar illness: (Please use other side if necessary)		

#### COMPLETE THIS SECTION IF CLAIM IS DUE TO AN ACCIDENT

Date of Accident:	Date of First Treatment:
Describe how, when and where accident occurred: (Please use other side for additional explanation)	

#### COMPLETE THIS SECTION IF YOU WERE CONFINED TO A HOSPITAL

Name of Hospital:	Date Admitted:	Date Discharged:
Hospital Address:	City:	State: Zip:

#### GIVE NAME AND ADDRESS OF PHYSICIAN(S) CONSULTED IN THE PAST 2 YEARS

Name of Physician	Address	City	State	Zip

### PART 2

#### AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health to give PROVIDENT AMERICAN INSURANCE COMPANY, or its representatives, any such information, including information relating to mental illness and/or use of drugs or alcohol. A photocopy of this authorization is to be considered as valid as the original.

**Patient's\* Signature:**



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\*Patient, Parent (if a minor). Next of Kin or Legal Representative (if patient deceased).

Date: \_\_\_\_\_