



Application for Benefits

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

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| Place of Employment | Group Number |
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EMPLOYEE STATEMENT

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

PATIENT & EMPLOYEE INFORMATION

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|---|--|---|--|---|--|
| 1. PATIENT'S NAME (First Name, Middle Initial, Last Name) | | 2. PATIENT'S DATE OF BIRTH | | 3. EMPLOYEE NAME (First Name, Middle Initial, Last Name) | |
| 4. PATIENT'S ADDRESS (Street, City, State, ZIP code) | | 5. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | | 6. EMPLOYEE ADDRESS (Street, City, State, ZIP code) | |
| PHONE # | | 7. PATIENT'S RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER | | 8. MARITAL STATUS: SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> | |
| 9. ARE YOU OR ANY OF YOUR DEPENDENTS EMPLOYED ELSEWHERE? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No B. An Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No Date/Description/Location of Accident _____ | |
| 13. IS PATIENT A FULL TIME STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes where? School: _____ Expected Date of Graduation _____ City: _____ | | | | 14. IF ELIGIBLE, IS PERSON ENROLLED IN: Federal Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Federal Medicare Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of Part A is _____ If Yes, Effective Date of Part B is _____ | |
| 15. ANY PERSON WHO, WITH INTENT TO DERAUD 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 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 SYSPTOMS? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Charges | | | | | | | |
| 26. DIAGNOSES OR NATURE OR ILLNESS OR INJURY - RELATED TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1,2,3, ETC. OR DX CODE | | | | | | | | | | | |
| 27. DATE OF SERVICE | A PLACE OF SERVICE | C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN | | D DIAGNOSIS CODE | E CHARGES | F | | | | | |
| | | PROCEDURE CODE | (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) | | | | | | | | |
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| 28. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements attached apply to this bill and are made a part hereof) | | | | 29. ACCEPT ASSIGNMENT <input type="checkbox"/> Yes <input type="checkbox"/> No | | 30. TOTAL CHARGES | | 31. AMOUNT PAID | | 32. BALANCE DUE | |
| SIGNED _____ DATE _____ | | | | 33. YOUR SOCIAL SECURITY NUMBER | | 34. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. I.D. NO. | | | | | |
| 35. YOUR PATIENT'S ACCOUNT NUMBER | | | | 36. YOUR EMPLOYER I.D. NO. | | | | | | | |

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