



P.O. Box 5079
Westlake Village, CA 91359

PPO-PROVIDER
YES **NO**
 NEW ADDRESS

INSTRUCTIONS TO EMPLOYEES

1. Fill out Employee's Statement below and sign the Authorization to Release information.
2. Have the provider fill out the Physician's Statement or attach an itemized copy of your bill complete with diagnosis.
3. Payment will be made to the Provider direct if you sign the authorization at the bottom on the back of this form.

ANY UNANSWERED QUESTIONS MAY CAUSE DELAY IN PROCESSING. PLEASE MAKE SURE ALL QUESTIONS ARE ANSWERED.

EMPLOYEE'S STATEMENT

A. EMPLOYER _____ DATE EMPLOYED _____

B. EMPLOYEE NAME _____ SOCIAL SECURITY NO. _____

C. Address (Street) _____ (City) _____ (State) _____ (Zip Code) _____

D. Description of accident or sickness _____ Date first symptoms of illness or injury appeared _____

E. IS THIS ILLNESS OR ACCIDENT in any way connected with Patient's occupation? YES NO
If yes, this form should not be completed. Notify your Supervisor and submit a Worker's Compensation First Notice of Injury Report through proper channels.

F. IF CONDITION IS DUE TO AN ACCIDENT, WHERE DID ACCIDENT OCCUR? (If vehicular accident, submit copy of Police Accident Report.)
 AT HOME IN A VEHICLE OTHER (WHERE) _____

DATE _____ TIME _____ TYPE OF INJURY _____

If vehicular accident, please indicate who was at fault SELF OTHER DRIVER YOUR DEPENDENT

Name and address of other party _____

Name and address of other party's Insurance Carrier _____

Name and address of your automobile Insurance Carrier _____

Do you have "NO FAULT" coverage in your State? YES NO

G. Are you or any of your dependents entitled to benefits under any other medical plan? YES NO
Name and address of Insurance Company _____

H. IF CLAIM IS FOR DEPENDENT, Name _____ Relationship _____ Age _____
Is subject dependent a full time student?

YES Name of Institution _____

NO Where employed _____ Full Time Part Time

I. Marital status _____ Name of spouse _____ Is spouse employed? YES NO

Where Employed _____ STREET CITY STATE ZIP

Spouse's Social Security No. _____

Was Dependent/Spouse covered under a plan to which his/her employer made contributions or provided payroll deductions when this condition began or when medical expense was incurred? YES NO

If yes, name of Insurance Company _____ . And, are your dependent children covered under your spouse's plan? YES NO

I certify that the above statements are correct to the best of my knowledge. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information, to release any and all information pertaining to the care or benefits provided to me or my dependents. A photostatic copy of this authorization shall be considered as effective as the original.

I AGREE to reimburse the Plan for any overpayment made to me or in my behalf due to error.

Date _____ Signature of Employee _____ Soc. Sec No. _____

Signature of Patient _____ Soc. Sec. No. _____

Required only if patient is spouse

