EBA&M
EMPLOYEE BENEFITS
ADMINISTRATION & MANAGEMENT

PO Box 17179
Irvine, CA 92623

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 Illness _____ 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 a 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 _____

I. Marital Status _____ Name of Spouse _____ Is Spouse Employed? ☐ YES ☐ NO
Where Employed _____
Street City State Zip

Spouse's Social Security Number _____
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

ATTENDING PHYSICIAN'S STATEMENT - PART 2

HEALTH CARE BENEFITS - GROUP - MEDICAL

PATIENT'S NAME AND ADDRESS

DATE OF BIRTH

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(if diagnosis code other than ICDA* used, give name):

2. IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

PREGNANCY? ☐ YES ☐ NO IF YES, APPROXIMATE DATE PREGNANCY COMMENCED

3. REPORT OF SERVICES (OR ATTACHED ITEMIZED BILL)
(IF PREVIOUS FORM SUBMITTED TO THIS HEALTH CARE PLAN YOU NEED TO SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE IF USED	CHARGES

†O - DOCTOR'S OFFICE
IH - Inpatient Hospital
NH - Nursing Home
H - Patient's Home
OH -Outpatient Hospital
OL - Other Locations
*ICDA - International Classification of Diseases

TOTAL CHARGES $

AMOUNT PAID $

BALANCE DUE $

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

6. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
IF "YES" WHEN AND DESCRIBE: ☐ YES ☐ NO

7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
☐ YES ☐ NO

8. DOES PATIENT HAVE OTHER HEALTH COVERAGE?
IF "YES" PLEASE IDENTIFY ☐ YES ☐ NO

9. NAME AND ADDRESS OF REFERRING PHYSICIAN, IF ANY

10. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED
(Unable to Work)
FROM _____ THRU _____

11. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

DATE PHYSICIAN'S NAME (PRINT) DEGREE

PHYSICIAN'S SIGNATURE TELEPHONE

INDIVIDUAL PRACTITIONER'S SS NO. / /

OR EMPLOYER ID NO /
(MUST BE FURNISHED UNDER AUTHORITY OF LAW)

STREET ADDRESS CITY OR TOWN STATE & ZIP CODE

PART 3 - ASSIGNMENT OF BENEFITS

Authorization to pay: *I hereby authorize payment directly to the Physician designated below of the surgical and or medical benefits, otherwise payable to me for his services as described above, but not to exceed the Maximum Allowable Amount for these services. I understand that I am financially responsible for the charges not covered by this authorization.*

PAY TO DR. _____
(Please Print)

DATE _____ SIGNED (Insured Person) _____