AULTCARE
AULTRA

MEDICAL AND RX FORM
APPLICATION FOR BENEFITS

Employee Statement
Each family member must complete one form annually at each physician office. ☐Active ☐Retired ☐Salaried ☐Hourly

Place of Employment	Group Number

PATIENT AND EMPLOYEE INFORMATION

PATIENT NAME First Name	Middle Initial	Last Name	Date of Birth
Street	City	State	Zip Code
Phone Number	Gender ☐Male ☐Female	Relationship to Employee ☐Self ☐Spouse ☐Child ☐Other	

EMPLOYEE NAME First Name	Middle Initial	Last Name	
Street	City	State	Zip Code
Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed			
Are you or any of your dependents employed elsewhere? ☐Yes ☐No			
If yes, name of company		Phone Number	
Employee ID Number (Social Security Number)			

OTHER GROUP HEALTH COVERAGE

Policyholder Name	Plan Name	Address	Policy Number

Was the condition related to any of these?
Patient's employment ☐Yes ☐No
Auto accident ☐Yes ☐No (If yes, please complete the information below based on the accident.)
Date _____ Description _____
Location _____

Is the patient a full-time student? ☐Yes ☐No (If yes, please complete the information below.)
Name of School _____ City _____ Expected Date of Graduation _____

If eligible, is the person enrolled in:
Federal Medicare Part A ☐Yes ☐No If yes, effective date for Part A _____
Federal Medical Part B ☐Yes ☐No If yes, effective date for Part B _____

Any person who, with intent to defraud or knowing they are 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.

Patient or Authorized Person Signature _____ Date _____

I authorize payment of medical benefits to undersigned physician or supplier for services described below.

Employee or Authorized Person Signature _____ Date _____

PHYSICIAN OR SUPPLIER INFORMATION (If patient completed this form, itemized receipts must be attached.)

Date of illness (first symptom), injury (accident), or pregnancy (LMP) _____

Date of first consultation for this condition _____

Has patient ever had same or similar symptoms? ☐Yes ☐No

Date patient is able to return to work _____

Dates of total disability _____ - _____ Dates of partial disability _____ - _____

Name of referring physician _____

Dates of service related to hospitalization Admitted _____ Discharged _____

Name of facility where services rendered (If other than home or office) _____

Address of facility where services rendered (If other than home or office)

_____

Was laboratory work performed outside your office? ☐Yes ☐No Charges _____

Diagnoses, nature, illness, or injury – related to procedure in column E by reference numbers 1, 2, 3, etc. or DX code.

A) Date of service	B) Place of service	C) Procedure code	D) Fully describe procedures, medical services, or supplies furnished for each date given (Explain unusual services or circumstances)	E) Diagnosis code	F) Charges		
					Total Charges	Amount Paid	Balance Due

Accept Assignment ☐Yes ☐No	Your Social Security Number			
Physician's or Supplier's Name				
Address	City	State	Zip Code	Phone Number
Your patient's account number		Your employer ID number		

I certify the statements attached apply to this bill and are made a part hereof.

Physician Signature _____ Date _____

Place of Service Codes

IH – Inpatient hospital
OH – Outpatient hospital
O – Doctor's office
4 H – Patient's home
5 – Daycare facility (PSY)
6 – Nightcare facility (PSY)
7 NH – Nursing Home
8 SNF – Skilled Nursing Facility
9 – Ambulance
O (OL) – Other locations
A (IL) – Independent Laboratory
B – Other medical/surgical facility