 Section A must be completed by the Insured in full. One of the following must be provided: Section B Fully Completed by the Attending Physician, or Fully Itemized Bills showing Claimant's Name, Nature of Illness/Injury, Description and Charge for each service provided. This form must be signed and dated in all applicable sections. This form and all attached bills must be submitted to the address indicated above. The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the 	Insurance Company of the State of Pennsylvania	PROOF OF LOSS	
P. O. Exot 15701 POLICY NUMBER: 9110452 Wilnington, D. E. 19805-5701 BOD-551-10824/302-661-4176 ACCIDENT AND SICKNESS CLAIM FORM/ GLOBAL NSTRUCTONS: ACCIDENT AND SICKNESS CLAIM FORM/ GLOBAL Section A must be completed by the facure of Interfacion of Madical Expanses. Section A must be completed by the facure of Interfacion of Madical Expanses. Section A must be signed and date in all applicable exections. The form manue be provided. Section A must be signed and date in all applicable exections. Construction of any lability on the Company, nor a waiver of any of the complexity. must not be compared date of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, nor a waiver of any of the control of any lability on the Company, and any of the control of any lability on the Company, any any of the control of any lability on the control of an	AIG Claim Services	NAME OF GROUP:	Diplomat America
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2.) Current Residence Address: 3.) Date of arrival in U.S.:	Claima	ant's Date of Birth:/	_/ Sex: □ Male □ Female
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CLAIMANT INFORMATION 1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG 1a. INSURED'S I.D. NUMBER OTHER □ (Medicare #) □ (Medicaid #) (Sponsor's SSN) □ (VA File #) □ (SSN or ID) (SSN) 2. PATIENT'S NAME (First Name, Middle Initial, Last Name) 3. PATIENT'S DATE OF BIRTH SEX 4. INSURED'S NAME (First Name, Middle Initial, Last Name) MM DD МΠ FΠ 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT'S RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) SELE D SPOUSE OTHER (SPECIFY) CITY STATE 8. PATIENT STATUS CITY STATE Single D Married D Other D ZIP CODE TELEPHONE NO. ZIP CODE TELEPHONE NO. Employed Full Time Student Part-Time Student) 9. OTHER INSURED'S NAME 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER A. OTHER INSURED'S POLICY OR GROUP NUMBER 3. PATIENT'S DATE OF BIRTH A. PATIENT'S EMPLOYMENT? SEX MM DD YΥ YES D NO 🗆 ΜП FΠ B. OTHER INSURED'S DATE OF SEX B. AN AUTO ACCIDENT? B EMPLOYER'S NAME OR SCHOOL NAME BIRTH MM DD YY М Π FΠ YES 🗆 NO 🗆 C. EMPLOYER'S NAME OR SCHOOL NAME C. INSURANCE PLAN NAME OR PROGRAM NAME C. OTHER ACCIDENT? YES NO D. INSURANCE PLAN NAME OR PROGRAM NAME D. RESERVED FOR LOCAL USE D. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES D NO D If ves. return to & complete item 9 A-D 12. PATIENT'S OR AUTHORIZED PERSONS' SIGNATURE. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to undersigned physician or supplier for service described I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below below. Signature Date Signature Date 14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: 16.Dates Patient Unable To Work in Current Occupation GIVE FIRST DATE: MM / DD / YY MM / DD / YY MM / DD MM DD / YY YΥ PREGNANCY (LMP) 1 FROM: 1 1 / 1 TO: 1 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. Hospitalization Dates Related to Current Services MM / DD MM / DD / YY / YY FROM: / / TO: / 19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES YES NO I | 22. MEDICAID RESUBMISSION 21, DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) ORIGINAL REF. NO. CODE 1 3 | 23. PRIOR AUTHORIZATION NUMBER 2 | 4 | 24 A B С F G Н 1 .1 PROCEDURES, SERVICES, OR SUPPLIES DIAGNOSIS DAYS DPSD RESERVED FOR DATE(S) OF SERVICE Type of Place of (Explain Unusual Circumstances) CODE \$ CHARGES COB FROM то OR Family EMG LOCAL USE CPT/HCPCS MM/DD/YY MM/DD/YY Service Service MODIFIER UNITS Plan 25. FEDERAL TAX I.D. NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE SSN EIN □ YES \$ \$ \$ п 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 33. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & INCLUDING DEGREES OR CREDENTIALS **TELEPHONE #** (I certify that the statements apply to this bill and are made office). a part thereof.) DATE . GRP# PIN# SIGNED PLACE OF SERVICE CODES

HEALTH INSURANCE CLAIM FORM

Section B

1-(H) - INPATIENT HOSPITAL	4-(H)-PATIENT'S HOME	7-(NH) NURSING HOME	O-(OL)-OTHER LOCATIONS
2-(OH) - OUTPATIENT HOSPITAL	5DAYCARE FACILITY (PSY)	8-(SNF)-SKILLED NURSING FACILITY	A-(IL)-INDEPENDENT LABORATORY
3-(0) - DOCTOR'S OFFICE	6NIGHT CARE FACILITY(PSY)	9AMBULANCE	BOTHER