



Application for Benefits

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

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

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 FULLTIME 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. A DATE OF SERVICE	B 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)			

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.					
35. YOUR PATIENT'S ACCOUNT NUMBER				36. YOUR EMPLOYER I.D. NO.		I.D. NO.			

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