Teachers Health Trust
P.O. BOX 96238
LAS VEGAS, NEVADA 89193-6238

TEACHERS HEALTH TRUST

CLAIM FORM

ENROLLEE INFORMATION – ENROLLEE SHOULD COMPLETE THIS SIDE (TYPE OR PRINT)

1. INSURED'S NAME _____
   FIRST MIDDLE LAST
2. SOCIAL SECURITY NUMBER ☐☐☐ - ☐☐ - ☐☐☐☐ GROUP NUMBER – 20660
3. HOME ADDRESS & TELEPHONE NUMBER ☐ CHECK IF NEW
   _____ ( )
   STREET ADDRESS CITY STATE ZIP TELEPHONE NUMBER
4. BIRTHDATE: _____ _____ _____ SEX: ☐ MALE ☐ FEMALE
   MONTH DAY YEAR
5. WORK STATUS: ☐ ACTIVE _____ ☐ RETIRED _____ ☐ OTHER _____
   (CHECK ONE & GIVE DATE)

PATIENT INFORMATION

6. PATIENT'S NAME _____ PATIENT'S SOC. SEC. NO. _____
   FIRST MIDDLE LAST
7. RELATIONSHIP TO INSURED _____
8. PATIENT ADDRESS IF NOT SAME AS INSURED _____
   STREET ADDRESS CITY STATE
9. BIRTHDATE: _____ _____ _____ SEX: ☐ MALE ☐ FEMALE
   MONTH DAY YEAR
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT? ☐ YES ☐ NO AN ACCIDENT? ☐ YES ☐ NO
    IF AN ACCIDENT, COMPLETE THE FOLLOWING: _____ _____ ☐ AM ☐ PM
    DATE OF ACCIDENT
11. DESCRIBE HOW AND WHERE ACCIDENT OCCURRED: _____

FAMILY INFORMATION

12. DOES INSURED OR ANY FAMILY MEMBER HAVE OTHER HEALTH INSURANCE? ☐ YES ☐ NO
    IF YES, COMPLETE THE FOLLOWING: NAME OF FAMILY MEMBER: _____ SSN: _____
    TYPE OF INSURANCE: ☐ OTHER EMPLOYER SPONSORED PLAN ☐ OTHER GROUP SPONSORED PLAN
    NAME & ADDRESS OF OTHER EMPLOYER OR GROUP:
    _____
    MEDICARE PART A ☐ YES ☐ NO EFFECTIVE DATE _____
    PART B ☐ YES ☐ NO EFFECTIVE DATE _____

AUTHORIZATION TO RELEASE INFORMATION

AUTHORIZATION TO OBTAIN INFORMATION

I / We jointly certify that the above information is complete, true and correct.
I / We hereby authorize all doctors, dentists, psychologists, pharmacists, hospitals or other institutions providing care, treatment, consultation, drugs or supplies to furnish TEACHERS HEALTH TRUST or its authorized representative with full information regarding history, physical or mental condition, consultation, treatment or psychotherapy rendered – including copy of their records.
I / We authorize any insurance carrier, service plan, union, trust fund, or employer to furnish TEACHERS HEALTH TRUST with information regarding benefits to which I/we may be entitled.
I / We authorize any college, university or other educational institution to furnish TEACHERS HEALTH TRUST with information determined necessary to TEACHERS HEALTH TRUST to establish student eligibility.
I / We also authorize TEACHERS HEALTH TRST to release any information relevant to a determination of the implementation of a coordination of benefits provision to any insurance carrier, service plan, union, trust fund, or employer requesting such information. A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ _____ _____ SIGN HERE
DATE PATIENT'S SIGNATURE (Parent if Patient is a Minor)

PAYMENT AUTHORIZATION

I AUTHORIZE LPAYMENT TO BENEFITS DIRECTLY TO THE PHYSICIAN OR SUPPLIER NAMED HEREIN FOR THE SERVICES DESCRIBED

_____ _____
INSURED OR AUTHORIZED PERSON'S SIGNATURE DATE

PHYSICIAN'S STATEMENT

PATIENT INFORMATION (TO BE COMPLETED BY INSURED)

1. INSURED'S NAME _____
   FIRST MIDDLE LAST
2. SOCIAL SECURITY NUMBER ☐☐☐ - ☐☐ - ☐☐☐☐

3. PATIENT'S NAME (FIRST, MIDDLE INITIAL, LAST NAME)	4. DATE OF BIRTH	5. RELATIONSHIP TO INSURED

PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN)

6. DATE FIRST CONSULTED FOR THIS CONDITION	7. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES ☐ NO ☐
8. NAME OF REFERRING PHYSICIAN	9. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE

10. HOSPITAL ADMISSION DATE	11. HOSPITAL DISCHARGE DATE	12. WAS PRE-OPERATIVE TESTING PERFORMED OUT OF HOSPITAL?

13. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.
RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NO. 1, 2, 3, ETC OR DX CODE
1.
2.
3.
4.

14. A DATE OF SERVICE	B* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE** (IDENTIFY:)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAG-NOSIS CODE	E CHARGES		F*** T.O.S.	G. LEAVE BLANK

15. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	16. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO IDENTIFYING NUMBER.	17. TOTAL CHARGE	18. AMOUNT PAID	19. BAL DUE
20. YOUR PATIENT'S ACCOUNT NO.		21. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NUMBER IS THIS A NEW ADDRESS? ☐ YES ☐ NO		

***PLACE OF SERVICE CODES**

1 – (IH)	- Inpatient Hospital	8 – (SNF)	- Skilled Nursing Facility
2 – (OH)	- Outpatient Hospital	9	- Ambulance
3 – (O)	- Doctor's Office	0	- Other Locations
4 – (H)	- Patient's Home	A	- Independent Laboratory
5 -	- Day Care Facility (PSY)	B	- Other Medical Surgical Facility
6 -	- Night Care Facility (PSY)	C	- Residential Treatment Center
7 -	- Nursing Home	D	- Specialized Treatment Facility

*****TYPE OF SERVICE CODES**

1 – Medical Care	8 – Assistance at Surgery
2 – Surgery	9 – Other Medical Service
3 – Consultation	0 – Blood or packed Red Cells
4 – Diagnostic X-Ray	A – Used DME
5 – Diagnostic Laboratory	M – Alternate Payment for Maintenance Dialysis
6 – Radiation Therapy	Y – Second Opinion on Elective Surgery
7 – Anesthesia	Z – Third Opinion on Elective Surgery

PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY