

American Sentinel Insurance Company/Aegis Security Insurance Company

P.O. Box 61140, Harrisburg, PA 17106-1140

Phone : (717) 540-0600 or 1-800-692-7338

Fax: (717) 657-9499

PLEASE PRINT

MEDICAL CLAIM FORM

1.	INSURED'S NAME (FIRST) (MI) (LAST)	SOCIAL SECURITY NO.	POLICY NO.
	ADDRESS (STREET)	(CITY)	(STATE) (ZIP)
	INSURED'S PHONE NUMBER ()	PATIENT'S SOCIAL SECURITY NO.	PATIENT'S BIRTHDATE (MO., DAY, YR.) / /
	GROUP NAME		

2.	PATIENT'S NAME (FIRST) (MI) (LAST)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO INSURED SELF __ SPOUSE __ SON __ HANDICAPPED DEP. __ DAUGHTER __ OTHER __
	IS THE PATIENT A FULL-TIME STUDENT OVER 19 YEARS OF AGE? __ YES (If "Yes," complete expected graduation date.) MO. DAY YR __ NO		

3.	WERE EXPENSES DUE TO AN ACCIDENTAL INJURY? __ YES __ NO (If "Yes," complete below.)		
	a. Date of accident (MO/DAY/YR)	Place/Type of incident	__ WORK __ SCHOOL __ MOTORCYCLE __ HOME __ AUTO __ OTHER ____
	b. Give a brief description of the incident _____		
	c. Has claim been or will claim be filed under any Worker's Compensation act? __ YES __ NO		
	d. Has claim been or will claim be filed against person responsible for the injury? __ YES __ NO		

4.	PRESCRIPTION DRUG INFORMATION	
	NAME OF MEDICATION(S)	CONDITION BEING TREATED
	1. _____	_____
	2. _____	_____
3. _____		
If you have more than three medications, please attach an additional sheet of paper.		

5.	DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS:	
	DIAGNOSIS, ILLNESS OR INJURY	NAME AND DEGREE OF PERSON TREATING ILLNESS OR INJURY
	a. _____	_____
	b. _____	_____
c. _____		
(Use additional paper if necessary.)		

6.	ASSIGNMENT OF BENEFITS	
	I authorize payment of benefits to the Physician or Supplier for services described herein. This authorization is invalid unless the Tax I.D. of the provider is given. I understand that I am financially responsible for all charges not covered by this authorization.	

Date	Signature of Insured	

7.	AUTHORIZATION		
	Any person who knowingly and with intent to defraud or other person who files a statement containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.		
	I authorize the release to and the use by American Sentinel Insurance Company of any medical or other information needed to process this claim. Authorization will remain in effect for twelve (12) months after I sign and date this form, unless otherwise specified. A photocopy of this authorization shall be as valid as the original.		
_____		_____	
Signed	Date	Patient or parent (If patient is a minor)	Date

TO BE COMPLETED BY ATTENDING PHYSICIAN			PLEASE PRINT
Name of Patient		Date of birth _____ / _____ / _____ Mo. Day Year	
1. Nature and origin of ___ Sickness ___ Injury	DIAGNOSIS, Primary & Secondary		
2. Is condition due to pregnancy	___ Yes ___ No	If "Yes" provide date of LMP _____ / _____ / _____ Mo. Day Year	
3. When did symptoms first appear or accident happen ____ / ____ / ____ Mo. Day Year	When was patient first diagnosed with this condition ____ / ____ / ____ Mo. Day Year	Date of last visit for this condition ____ / ____ / ____ Mo. Day Year	
4. Is condition due to injury or sickness arising out of patient's employment	___ Yes ___ No ___ Unknown	If "Yes" explain	
5. Dates, place, and nature of treatment other than surgical, and medications prescribed, if any			
6. Surgical or obstetrical procedure, if any. Describe fully and give approach used if more than one is possible	Date _____ Procedure Name _____ _____ Operative report attached ___ Yes ___ No	Describe fully if no operative report attached	
7. Is patient still under your care for this condition	___ Yes ___ No ___ Referred to another physician (list on 8 below)		
8. Names and addresses of other treating physicians	(a)	(b)	
9. If patient hospitalized, give name and address of hospital	Hospital _____ City _____ State _____ From _____ To _____		
10. Has patient ever had same or similar condition. If "Yes" state when and describe	___ Yes ___ No		
11. Is patient now totally disabled	___ Yes ___ No What restrictions have you placed on the patient's activities		
REMARKS			
Name (Attending Physician) Print		Degree	Must be furnished under authority of law.
Street Address		City State ZIP Code	Individual Practitioners SS#
Signature	(Area Code)Telephone No.	Date	All Others-Employer I.D.#

To Avoid Delay Please Answer All Questions Applicable

This form is supplied by Insurer upon request without verification of the status of the Insurance.
Verification will be made upon receipt of the completed form.

INSTRUCTIONS ON FILING A CLAIM

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| 1. ANSWER ALL QUESTIONS COMPLETELY AND ACCURATELY | 6. SEND THE COMPLETED FORM DIRECTLY TO
CLAIMS ADMINISTRATOR
AMERICAN SENTINEL INSURANCE COMPANY
P.O. BOX 61140
HARRISBURG, PA 17106-1140 |
| 2. HAVE YOUR ATTENDING PHYSICIAN COMPLETE THE ABOVE IN FULL | |
| 3. ATTACH ITEMIZED BILL REFLECTING TYPE OF SERVICE, DATE OF SERVICE,
AND AMOUNT CHARGED | |
| 4. SECTIONS MUST BE COMPLETED | |
| 5. CALL 1-800-692-7338 FOR ADDITIONAL CLAIM FORMS | |

ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT, MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME, SUBJECT TO CRIMINAL PROSECUTION AND CIVIL PENALTIES.