MEDICAL CLAIM FORM

INSTRUCTIONS

1. Employee/Member completes information below and attaches itemized statements and bills to this form.
2. Use a separate form for Employee/Member and each dependent.
3. **All bills must be itemized and include the patient's name, date of service, amount charged for service and diagnosis.** Expenses may be submitted by having your doctor complete an Attending Physician's Statement which your doctor will provide. Do not submit photocopies, cash register receipts or cancelled checks. Make copies of all claims before they are submitted. Claim personnel cannot provide copies.
4. **SEND COMPLETED CLAIM FORM & ALL RELATED BILLS TO THE CLAIM OFFICE ADDRESS SHOWN ON YOUR ID CARD.**

EMPLOYER & EMPLOYEE / MEMBER INFORMATION

Name and Address of Employee	Member's EMPLOYER (Group Policyholder)	Policy Number
	Nashville Electric Service	NES

Name of Employee / Member	Social Security Number or Alternate ID	Employee / Member Date of Birth

Employee / Member Home Address (Street, City, State, Zip Code) ☐ Check Box if new Address

Daytime Phone Number (Include Area Code)	Gender	Marital Status	Custody of Children
( )	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Widowed	☐ Yes ☐ No

Name of Patient	Patient's Date of Birth

Name of Spouse	Spouse's Social Security Number	Spouse's Date of Birth

Is Spouse Employed? Yes ☐ No ☐ If Yes, Give Name, Address and Phone Number of Spouse's Employer

OTHER INSURANCE INFORMATION

Are Hospital, Surgical or Medical Benefits or Services Provided under ANY OTHER Employer, Union, Student or Association Group Plan or Governmental Program applicable to this claim? ☐ Yes ☐ No **If yes, please complete the following information:**

Name of Employee / Member	Employee / Member's Social Security Number

Name of Group Policyholder — Policy Number

Address of Policyholder

Name of Carrier Providing Benefits — Carrier Phone Number (Include Area Code) ( )

Address of Carrier

SIGNATURE & AUTHORIZATION

It is a crime to complete this form with information which you know is false or to omit any facts which you know are important.

Employee / Member Signature: ______________________________ Date:

Authorization to Release Information: I authorize the release of any information necessary to process this claim.

Signature: ______________________________
(Patient or Parent if Minor)

I authorize payment of Medical Benefits to the Provider(s) whose charges are attached.

______________________________ Signature:
(Employee / Member)