



# EDUCATORS MUTUAL

YOUR Insurance Company

852 EAST ARROWHEAD LANE MURRAY, UTAH 84107-5298 TELEPHONE: 262-7475

IN UTAH: 1(800) 662-5851

OUT OF STATE: 1(800) 362-0533

## MEDICAL CLAIM FORM

1. Employer (District, College, University) \_\_\_\_\_

Medicare  Conversion

### A. EMPLOYEE INFORMATION

2. Name _____	3. S.S. No. ____/____/____	4a. Employee Birthdate ____/____/____
5. Address _____ City _____ State _____ Zip _____	4b. Spouse Birthdate ____/____/____	
Check If New Address <input type="checkbox"/>	6. Phone: Work _____	Home _____

### B. PATIENT INFORMATION (If patient is employee, skip this box and go to C)

7. Name _____	8. Relationship to Employee _____	9. Date of Birth _____
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### C. OTHER INSURANCE AND EMPLOYMENT INFORMATION

10. Is patient covered by other medical insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> (your own, Medicare, your spouses, other involved party)	<b>IF NO, GO TO D</b>	Effective date _____	or Cancellation date _____
11. Name of Policyholder _____		S.S. No. ____/____/____	
12. Name of other Employer _____			
13. Name of other Insurance Company _____			
14. Address _____		City _____	State _____ Zip _____

### D. ACCIDENT/ILLNESS

<b>ACCIDENT</b> If claim is for an injury, complete this section.	15. Describe injury _____ _____ 16. Date of accident ____/____/____ Where? _____ 17. Accident related to employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	18. Auto Related? Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>ILLNESS</b> If claim is for an illness, complete this section.	19. Describe illness (diagnosis) _____ _____ _____	

### E. AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT

20. Do you want the payment to go directly to the provider (doctor, lab, hospital, etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>If box is not checked, payment will be sent to you.</b>
I certify that the above information is correct and complete and authorize Educators Mutual and/or providers of health care to secure or release information relating to this claim.	
21. _____	Date _____
Patient's or Authorized Person's Signature	

ATTACH ITEMIZED STATEMENT OF SERVICES RENDERED BY PROVIDER OF SERVICES AND (IF APPLICABLE)

CHECK HERE

ATTACH EXPLANATION OF BENEFITS PAID BY MEDICARE OR OTHER INSURANCE CARRIER.

CHECK HERE

## HELP US PROCESS YOUR CLAIM

Claim forms approved by Educators Mutual are available at your school or employer's personnel office or by writing to Educators Mutual at 852 East Arrowhead Lane, Murray, Utah 84107-5298.

1. Complete and sign the claim form. If you want benefits paid directly to the physician or hospital, check the appropriate box.
2. Attach an itemized billing. The itemized bill must contain date of service, services rendered, amount charged and diagnosis. Be sure the physician has included the RVS or CPT numbers for all services. (Cancelled checks will not be accepted as proof of service.)
3. An approved hospital claim form will be accepted for all inpatient hospital services.
4. Once you have filed a claim, file continuing expenses every six months or after expenses exceed \$100. Claims not submitted within 12 months of date of service will be denied.
5. If you have coverage under another *GROUP* policy (not an individual policy), attach a copy of the settlement sheet from your other insurance carrier showing payment or rejection of charges. PLEASE NOTE: Even though your other policy has a deductible, the charges should be filed with your other carrier to establish your deductible. Attach copies of all itemized medical bills or statements.
6. We suggest you keep copies of claims and the settlement sheets for your records. A FEE WILL BE CHARGED FOR DUPLICATE COPIES.