MEDICAL CLAIM FORM

PROVIDER SUPPORT:
1.954.331.6530, OPTION 4

Forward Form and Bills to:
JIPA Network/Claims
PO Box 2788
Kennesaw, GA 30156-9114 USA
fax: 1.770.810.3789
email: claims@jipanetwork.com

(Please Print)

Group/Plan Name or Number:		Insured's ID Number:	
PART 1 MUST BE COMPLETED BY INSURED			
Insured's Last Name: First: Middle:		Patient's Birth Date: mm/dd/yyyy	Patient's ID Number:
Patient's Last Name: First: Middle:		Patient's Gender: ❑ M ❑ F	Patient's Relationship to Insured:
Street Address:		Home Phone #: ( ) EMail Address:	Cell Phone #: ( )
City/Town:		Parish/State:	ZIP/Postal Code:
Date the Patient's Accident or Sickness Began:	Did Accident Happen at Work? ❑ Yes ❑ No	Has Claim Been Filed with Workers Comp?	Is the Patient a Full Time Student? ❑ Yes ❑ No If Yes, give Name and Address of School:
Is the Insured or Patient Covered under any Other Plan? ❑ Yes ❑ No		If Yes, give Name, Address and Policy Number of Plan Providing Benefits:	

ASSIGNMENT OF BENEFITS

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits. I certify the information provided is true and correct to the best of my knowledge.

X _____ _____
Patient's Signature *Date*

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S):
I hereby authorize payment of benefits directly to Providers submitting claims on my behalf. This payment shall not exceed my indebtedness to the Providers and I have agreed to pay, in a current manner, any charges determined to be not covered by the plan benefits.

x _____ _____
Patient's Signature *Date*

PART 2 TO BE COMPLETED BY PROVIDER OF SERVICE

REPORT OF SERVICES *(OR ATTACH AN ITEMIZED BILL)*	Date Patient First Consulted You for this Condition:
Patient's Diagnosis and Concurrent Conditions:	Has Patient Ever Had Same or Similar Condition? ❑ Yes ❑ No If Yes, Provide Dates and Descriptions:

Service Date: mm/dd/yyyy	Place of Service:	Procedure Code (and Modifier):	Description of Surgical or Medical Services Rendered:	Charges:	Currency Type:
			Total Charges:		
			Amount Paid:		
			Balance Due:		

Provider Name, Address and Specialty:

Phone Number: ( ) .

Email Address: _____

Company TIN: ___ _____

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees.

_____ _____
Provider of Service Signature *Date*