CONSOCIATE HEALTH

INSURANCE CLAIM FORM

1. INSURED'S ID NUMBER		1 b. INSURED'S SSN
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE GENDER MM / DO / YY M F	4. INSURED'S NAME (Last Name, First Name, MI)
5. PATIENT'S ADDRESS (No, Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Employee Other	CITY / STATE
ZIP CODE / TELEPHONE (INC. AREA CODE)		ZIP CODE / TELEPHONE (INC. AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, MI)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) Yes No	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DATE OF BIRTH GENDER MM / DO / YY M F
b. OTHER INSURED'S DATE OF BIRTH SEX MM / DO / YY M F	b. AUTO ACCIDENT? Yes No	b. EMPLOYERS NAME
c. EMPLOYER'S NAME	c. OTHER ACCIDENT? Yes No	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10 a. IF YES, PLEASE PROVIDE DATE & DETAILS.	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes No
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of my medical or other information necessary to process this claim. Signed Date		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to be sent to the physician or supplier for services as attached. Signed Date

Please attach all itemized receipts and send to:

Consociate Health Customer Service
customerservice@consociate.com
Phone: 800-798-2422 **Fax:** 217-423-4575

Consociate Health
PO Box 1068
Decatur, IL 62525