1. Complete this form
2. Attach all bills
3. Mail to

SAN DIEGO COUNTY SCHOOLS FRINGE BENEFITS CONSORTIUM

MEDICAL CLAIM

6401 LINDA VISTA ROAD #505
SAN DIEGO, CALIFORNIA 92111-7399
(858) 292-3542 or Toll Free (888) 233-7915
FAX (858) 569-5086

MAIL CLAIM TO:
San Diego & Imperial County Schools
Fringe Benefits Consortium
P O Box 211578
Eagan MN 55121

FILL OUT A SEPARATE FORM FOR EACH MEMBER SUBMITTING BILLS FOR COVERED SI
PLEASE PRINT OR TYPE.

PART I: *Must be Completed by Employee*

1. NAME OF EMPLOYER — DISTRICT
2. GROUP NO. J P A K _ _ _ _ _ _
3. EMPLOYEE NAME — LAST FIRST MI
4. SOCIAL SECURITY NO.
5. MARITAL STATUS
6. MAILING ADDRESS
7. EMPLOYEE BIRTHDATE / /
8. TELEPHONE NUMBER
9. CITY STATE ZIP
10. PATIENT NAME (IF OTHER THAN EMPLOYEE)
11. PATIENT BIRTHDATE / /
12. PATIENT S RELATIONSHIP TO EMPLOYEE — SELF ☐ SPOUSE ☐ SON ☐ DAUGHTER ☐
13. IF CHILD, FULL TIME STUDENT? ☐ YES ☐ NO
14. DATE OF INJURY OR START OF ILLNESS / /
15. NATURE OF ILLNESS, OR IF INJURED, HOW/WHERE DID INJURY OCCUR AND FIRST DATE OF TREATMENT — THIRD PARTY INVOLVED? YES ☐ NO ☐
16. ARE ANY OF THE ILLNESSES OR ACCIDENTS FOR WHICH CLAIM IS BEING MADE RELATED TO EMPLOYMENT? ☐ YES ☐ NO
17. NAME AND ADDRESS OF *PATIENT'S* EMPLOYER
18. SOC. SEC. #
19. ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANY OTHER GROUP INSURANCE HEALTH MAINTENANCE ORGANIZATION, OR GOVERNMENT PLAN (E.G. MEDICARE, MEDI-CAL, MEDICAID)? ☐ YES ☐ NO
20. POLICY # — EFFECTIVE DATE ___/___/___
21. NAME & ADDRESS OF INSURANCE CARRIER OR PLAN — EFFECTIVE DATE & PHONE #
22. PATIENT OR AUTHORIZED PERSON S SIGNATURE — I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I CERTIFY THE ABOVE INFORMATION IS CORRECT. (SEE ITEM #6, OVER) X DATE
23. EMPLOYEE OR AUTHORIZED PERSON — I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. X DATE
24. EMPLOYEE OR AUTHORIZED PERSON — I CERTIFY THAT THIS CLAIM HAS BEEN PAID IN FULL. MAKE PAYMENT OF MEDICAL BENEFITS TO THE EMPLOYEE. X DATE

PART II: *To be Completed by Physician (or attach itemization)*

25. PATIENT S NAME
26. DATE OF BIRTH
27. DOES PATIENT HAVE OTHER INSURANCE COVERAGE? ☐YES ☐ NO IDENTIFY:
28. DATE OF ILLNESS (FIRST SYMPTOM) ACCIDENT OR PREGNANCY (LMP):
29. DATE FIRST CONSULTED REFERRING PHYSICIAN:
30. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO DATE:
31. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
   1.
   2.
   3.
   4.

WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES:

A DATE OF SERVICE	B PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE* (IDENTIFY)*	(Explain unusual services or circumstances)	D DIAGNOSIS CODE	E CHARGES	F

PHYSICIAN S NAME — DEGREE — SIGNATURE — SOCIAL SECURITY NO

ADDRESS — CITY — ZIP CODE — TELEPHONE — EMPLOYER ID #

*PLACE OF SERVICE CODES

1 - (IH) = INPATIENT HOSPITAL
2 - (OH) = OUTPATIENT HOPSITAL
3 - (O) = DOCTOR S OFFICE
4 - (H) = PATIENT S HOME
5 - (PSY) = DAY CARE FACILITY
6 - (PSY) = NIGHT CARE FACILITY
7 - (NH) = NURSING HOME
8 - (SNF) = SKILLED NURSING FACILITY
9 - AMBULANCE
O - (OL) = OTHER LOCATIONS
A - (IL) = INDEPENDENT LAB
B - OTHER MEDICAL/SURGICAL FACILITY