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GROUP HEALTH OUT PATIENT CLAIM FORM

TO AVOID RETURN OF CLAIM FORM DUE TO INCOMPLETE INFORMATION, PLEASE ANSWER ALL QUESTIONS

Name of Employer			
Name of Employee		Name of Patient (If other than employee)	
Position/Rank	Relationship with Employee	Date of Birth (MM/DD/YYYY)	Sex
Email Address		Bank Account Name and Number	

I certify the above information to be true and accurate and I hereby authorize release of related information requested on this form by doctor or hospital.

EMPLOYEE'S SIGNATURE _____ YEAR/MONTH/DAY _____ PATIENT'S (IF ADULT) SIGNATURE _____ YEAR/MONTH/DAY _____

THIS PART MUST BE COMPLETED BY THE ATTENDING PHYSICIAN

Diagnosis	Surgical Procedure (if applicable)	Recommended Lab Test and Special Consultation

I hereby certify that, to the best of my knowledge and belief, the above information is accurate.

PRINTED NAME AND SIGNATURE _____ LICENSE NO. _____ TIN _____ OFFICE TEL. NO. _____ DATE OF CONSULTATION _____

THIS PART MUST BE COMPLETED BY THE EMPLOYER

PRINTED NAME AND SIGNATURE OF AUTHORIZED SIGNATORY _____ POSITION/TITLE _____ YEAR/MONTH/DAY _____

OUT PATIENT CLAIMS INSTRUCTIONS: 1. Please attach the original receipt(s) for doctor's fees, medicines, laboratory and X-ray fees. Tape receipts are not accepted. **2.** Please attach prescription ofmedicines. **3.** The doctor must write the name of the patient on his/her receipt. **4.** Please sign and complete this form.