Print

Principal Financial Group

Administered by

**Principal Life Insurance Company**

## *Medical Claim*

**Please mail completed form to:**
Principal Life Insurance Company
PO Box 39710
Colorado Springs, CO 80949-3910
For Questions: Please refer to the toll free number printed on your ID card.

**Please Note:**

- Provide information as indicated to avoid delay in the processing of this claim.
- If the hospital requests verification of coverage, the hospital may call Principal Life Insurance Company toll free Nationwide 1-800-533-5044.

**Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.**

## Part A Employee Information

Employee's name (first, middle, last) | **Plan and I.D. numbers (printed on I.D. card)** Plan | I.D.

Employee's (mo/day/year) birthdate | Employee's employer | Employee's employment date

Is employee still working? ☐ yes ☐ no | If "no" give date last worked | Is employee ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

## Part B Patient Information (Complete a separate form for each patient.)

**For whose expenses is claim being made?** **(If patient is other than self, answer questions 1-8 in this section.)**

☐ Self (If "self," go to questions 4, 5, 6, 7, 8) ☐ wife ☐ husband ☐ son ☐ daughter ☐ stepchild ☐ foster child

1. Patient's (mo/day/year) birthdate | 2. Patient's name (first, middle, last)

3. Patient's occupation *(If patient is over age 18 and a student, please indicate name and address of school.)*

3a. Student's social security number | 3b. Number of hours or units being taken by student | 4. This claim is the result of ☐ illness ☐ injury | 5. Is it employment related? ☐ yes ☐ no

6. Date occurred | 7. If injury, place it happened

8. Describe illness/injury

## Part C Other Insurance Information

(Complete if: **a.** this is the first claim for this illness or injury **- or –** **b.** you have not submitted a completed claim form in the last six months.)

If Employee is married, give spouse's name (if other than patient) | Spouse's date of birth (if other than patient) | Spouse's social security number

Is spouse employed? ☐ yes ☐ no | If "yes," give name, address and telephone number of spouse's employer.

If "yes," does spouse's employer provide group medical coverage? ☐ yes ☐ no | If "yes," please list any family members covered by this plan? | If "no," please explain

If patient is covered by any other medical plan, group policy, prepayment plan, Medicare or other Government plan, please provide the following information:

Name of person(s) carrying the other coverage | Name of group (employer, association, etc.)

Policy or plan number | Name and address of insurance company or plan

These statements are true and complete to the best of my knowledge. ▶ Signature of Employee | Date

**Part D Authorization for Release of Information** (Complete for every claim)

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Principal Life and the planholder, or their representatives, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization.

▶ Signature of employee | Date

▶ Signature of patient (required only if patient is spouse) | Date

Address of employee (street number, city, state, ZIP code)

Is this a new address? yes no | Please furnish a daytime telephone number in case we need to reach you. Area code ( )

**Medical Claim Form** *(Read directions before completing this form.)*

**Authorization to Pay**
*(Sign here only if you want benefits paid directly to Patient's doctor, hospital, or other provider of medical care.)*

I authorize payment of medical benefits to physician or supplier for service described below or on attached bill.

SIGNED *(Authorized Person)* DATE

1. Attach an itemized bill including diagnosis – **or –** 2. Have patient's physician or supplier complete their portion of this form below.

Patient's name (first, middle, last)

## PHYSICIAN OR SUPPLIER INFORMATION

9. DATE OF CURRENT: MM DD YYYY ◀ Illness (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)

10. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YYYY

11. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YYYY FROM MM DD YYYY TO

12. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

12A. I.D. NUMBER OF REFERRING PHYSICIAN

13. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YYYY FROM MM DD YYYY TO

14. RESERVED FOR LOCAL USE

15. OUTSIDE LAB? ☐ Yes ☐ No $ CHARGES

16. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 or 4 TO ITEM 19E BY LINE.)
1. ____ • ____ 3. ____ • ____
2. ____ • ____ 4. ____ • ____

17. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

18. PRIOR AUTHORIZATION NUMBER

| 19. | A DATE(S) OF SERVICE From MM DD YYYY | A To MM DD YYYY | B Place of Service | C Type of Service | D Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT/HCPCS | D MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |

20. FEDERAL TAX I.D. NUMBER ☐ SSN ☐ EIN

21. PATIENT'S ACCOUNT NO.

22. ACCEPT ASSIGNMENT ☐ YES ☐ NO

23. TOTAL CHARGE $

24. AMOUNT PAID $

25. BALANCE DUE $

28. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS SIGNED DATE

27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

28. PHYSICIAN'S SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

*PLACE OF SERVICE CODES
1 – (H) – INPATIENT HOSPITAL
2 – (OH) – OUTPATIENT HOSPITAL
3 – (C) – CLINIC
4 – (H) – PATIENT'S HOME
5 – DAY CARE FACILITY (PSY)
6 – NIGHT CARE FACILITY (PSY)
7 – (NH) – NURSING HOME
8 – (SNF) – SKILLED NURSING FACILITY
9 – AMBULANCE
O – (OL) – OTHER LOCATIONS
A – (IL) – INDEPENDENT LABORATORY
B – – OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88