# MEDICAL PAYMENT CLAIM FORM

## SECTION 1: CLAIMANT INFORMATION *Please print*

NAME OF INJURED PARTY ______________________ CLAIM NUMBER ______________________

IF MINOR, INCLUDE PARENT/GUARDIAN NAME ______________________

SOCIAL SECURITY NUMBER ______________ GENDER ______________ DATE OF BIRTH ______________

ADDRESS ______________ CITY ______________ STATE ______ ZIP CODE ______

Exact date of injury: ________/________/________ Time of day: ______________

Where did injury occur (include district name and building): ______________________

Description of incident leading to injury: ______________________

Part of body injured: ______________________

Medical treatment sought? ❍ YES ❍ NO When: ______/______/______ to ______/______/______

Where? Name of treatment facility (list all): ______________________

Witnesses (please provide names and contact information of all witnesses if known): ______________________

## SECTION 2: INSURANCE INFORMATION

Is the injured party covered by any health care coverage (including coverage under parents/guardians plan)? ❍ YES ❍ NO

Is the injured party covered by MEDICAID? ❍ YES ❍ NO

Is the injured party covered under any MEDICARE coverage? ❍ YES ❍ NO

NAME OF HEALTH CARE COVERAGE/PLAN ______________ MAILING ADDRESS ______________ CITY ______________ STATE ______ ZIP CODE ______

POLICY/CONTRACT NUMBER ______________ GROUP NUMBER ______________ GUARANTOR NAME ______________

## SECTION 3: MEDICAL AUTHORIZATION

**MEDICAL AUTHORIZATION:** I hereby state the above information is true and correct to the best of my knowledge. I authorize the release of ______________ medical documentation and other information which may be in the possession of any insurer, medical provider, physician, hospital, ambulance service or nurse, to any representative of **SET SEG** regarding my injuries, medical history, and physical and mental condition both prior to and subsequent to the date of this authorization, regardless of lapse of time. Upon presentation of this authorization or a photocopy of the authorization, you are authorized to release a copy of my medical records to any representative of SET SEG for the purpose of investigating an insurance claim. I understand that the information disclosed pursuant to this medical authorization may **NOT** be re-disclosed to another party without my written consent. **THIS IS NOT A RELEASE OF MY INSURANCE CLAIM**. The purpose of the disclosure is at my request and this Medical Authorization shall be deemed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). This Medical Authorization shall expire upon final resolution of my pending claim with SET SEG. I understand that I may revoke this Medical Authorization at any time by sending a written notice to my medical providers or to SET SEG.

SIGNATURE ______________________ DATE ______________