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Adair County Government Employee Dependent Claim Form

FAX: 417-883-8261

⇒ **PART I COMPLETE FOR ALL CLAIMS (TO BE COMPLETED BY EMPLOYEE ONLY)**

Employee's Name: _____

Social Security#: _____ Date of Birth: _____

Home Address: _____
(Number) (Street/Apt#) (City) (State) (Zip)

⇒ **PART II COMPLETE FOR DEPENDENT CLAIM ONLY**

Dependent's Name: _____ Date of Birth: _____ Male Female

Relationship: Spouse Son Daughter Other: _____

⇒ **PART III COMPLETE FOR ALL CLAIMS**

If you or your dependents were covered by another health plan, insurance carrier or government sponsored health plan prior to this coverage, please provide us with a copy of your Certificate of Creditable Coverage from the previous Carrier.

Is the person for whom claim is made covered under any other Group Health Plan or Medicare? Yes No

Insured Member's Name: _____ Social Security# _____

Name of other Insurance Co.: _____ Group/Contract Number: _____

Address: _____ Telephone Number: () - _____ Ext: _____
(Number/Street) (City) (State) (Zip)

⇒ **PART IV COMPLETE FOR ACCIDENT CLAIMS**

Date of Accident: _____ Was the patient at work when the accident happened? Yes No Auto Accident? Yes No

Describe where and how the accident happened:

Is a third party insurance company responsible (e.g. automobile insurance, home owners etc.)? Yes No
(If yes, please provide name of insurance company, address, phone number and group or contract # on the back of this form).

⇒ **PART V COMPLETE FOR SICKNESS CLAIMS**

Nature of Sickness: _____ Was patient at work when sickness began? Yes No

Will you or your dependent be filing for Worker's Compensation? Yes No

I/We certify that the above information is true and correct. I/We authorize the release of any medical or other information necessary to evaluate and complete the review and processing of any claims for reimbursement. A photocopy of this authorization shall be considered as valid as the original.

Signature of Employee: _____ Signature of Spouse: _____ Date: _____
(If patient)