



**First Health  
Preferred  
Provider  
Network**

**MAIL FORM TO:  
Klais & Company, Inc.  
Benefit Consultant and Administrators  
1867 West Market Street  
Akron, Ohio 44313-6977  
Tele: 800-331-1096**

*United States Fire Insurance  
Company*

**TO BE COMPLETED BY INSURED PERSON**

1. School Name: \_\_\_\_\_ Policy #: \_\_\_\_\_
2. Insured Person: \_\_\_\_\_ Group #: \_\_\_\_\_
3. Local Address: \_\_\_\_\_
4. Home Address: \_\_\_\_\_
5. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Local Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_
6. Are you an OPT Student?  Yes  No 7. What type Visa do you hold? \_\_\_\_\_
8. Patient Status:  Male  Female  Single  Married Plan Member ID \_\_\_\_\_
- Is this Claim for a dependent?  Yes  No If yes, give name: \_\_\_\_\_
- Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**COMPLETE THIS SECTION FOR ACCIDENT CLAIM**

9. Is this claim the result of an accident?  Yes  No If yes, give date of accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Accident: \_\_\_\_\_
10. Is this claim the result of a work-related injury?  Yes  No
- Is this claim the result of an auto accident?  Yes  No
- Is this claim the result of sports participation?  Yes  No If "yes"  intercollegiate  intramural  club  other
11. Where did the accident occur? \_\_\_\_\_
- How the accident did happen? \_\_\_\_\_

**COMPLETE THIS SECTION FOR SICKNESS CLAIM**

12. Name of physician: \_\_\_\_\_ Date of initial service: \_\_\_\_/\_\_\_\_/\_\_\_\_
13. Description of Illness: \_\_\_\_\_
14. Has the patient been treated for the above condition(s) in the last 12 months?  Yes  No
- If "yes" give condition(s) treated for and date(s) of treatment: \_\_\_\_\_

**COMPLETE THIS SECTION FOR ALL CLAIMS (ACCIDENT OR SICKNESS)**

15. Is patient covered for benefits by any Group Health, Employer, Union, Welfare Plan or Parent Health Plan?  Yes  No
- Other coverage provided through: Name of Person \_\_\_\_\_ Relationship \_\_\_\_\_
- If answered "yes" please complete the following:
- Insurance Co. or Benefit Plan \_\_\_\_\_ Employer or Sponsor \_\_\_\_\_
- Address \_\_\_\_\_ Address \_\_\_\_\_
- Telephone: \_\_\_\_\_ Telephone \_\_\_\_\_
- Policy # \_\_\_\_\_ Please include a photocopy of other plan identification card, if available

**COMPLETE THIS SECTION IF HEALTH CENTER REFERRAL IS NEEDED**

16. Date seen at health center \_\_\_\_/\_\_\_\_/\_\_\_\_ / Authorized signature \_\_\_\_\_
- I did not go to the health center because: (check one)  I was not in the area  it was an emergency  the health center was closed
17. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.

It is unlawful to knowingly provide false, incomplete or misleading facts or information regarding a claim for the purpose of defrauding or attempting to defraud to receive benefits. Penalties may include imprisonment, fines, denial of benefits and/or civil damages. For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature of Insured Person \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_

Patient's or Authorized Person's Signature \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_

**COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)**

Authorization to Pay Benefits: I hereby authorize payment directly to: any physician or provider of service for which I am submitting attached billings and charges. For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization

Signature