



MUTUAL MEDICAL

MEDICAL CLAIM

Mail To: Mutual Medical Plans, Inc. P.O. Box 689 Peoria, IL 61652

PLEASE TYPE OR PRINT

1 NAME OF PATIENT (Last, First, and Initial) DATE OF BIRTH SEX RELATIONSHIP OF PATIENT TO EMPLOYEE

2 WHAT IS THE ILLNESS OR INJURY REQUIRING TREATMENT? (if injury, how did it happen?)

3 WAS TREATMENT THE RESULT OF AN ACCIDENT? If yes, give: Date of Accident Place of Accident

4 WAS ILLNESS OR INJURY IN ANYWAY WORK CONNECTED?

5 IS PATIENT COVERED UNDER ANY OTHER HEALTH BENEFIT PLAN (individual or group)? (IF "YES" COMPLETE THE REMAINDER OF THIS SECTION)

NAME OF INSURING CO. ADDRESS NAME OF POLICY HOLDER BIRTHDATE SEX RELATIONSHIP TO EMPLOYEE TYPE OF COVERAGE IDENTIFICATION NUMBER OF OTHER COVERAGE EFFECTIVE DATE OF COVERAGE

6 TO BE COMPLETED REGARDLESS OF AGE OF PATIENT (SEE REVERSE SIDE FOR INSTRUCTIONS) IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE HOSPITAL INSURANCE (PART A) IS THE PATIENT ENTITLED TO BENEFITS UNDER MEDICARE MEDICAL INSURANCE (PART B) IF "YES" GIVE EFFECTIVE DATE OF ENROLLMENT FROM MEDICARE ID CARD

7 NAME OF EMPLOYEE (Last, First, and Initial) MEMBER LETTER AND NUMBER FROM ID CARD ADDRESS State Zip Code

I certify the above is correct and complete and I understand that cases of fraud will be criminally prosecuted. I authorize the release of any information necessary to process this claim.

SIGNATURE OF EMPLOYEE DATE PHONE

ITEMIZED BILLS WITH DIAGNOSIS MUST BE ATTACHED (SEE INSTRUCTIONS ON REVERSE SIDE)

**ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES  
MUST BE ATTACHED AND THE ITEMIZED BILLS MUST CONTAIN:**

- NAME OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICES OR SUPPLIES
- NAME OF THE PATIENT RECEIVING THE SERVICES OR SUPPLIES
- DATE EACH SERVICE OR SUPPLY WAS PROVIDED
- CHARGE FOR EACH SERVICE OR SUPPLY
- DESCRIPTION OF THE SERVICES OR SUPPLIES PROVIDED

**IN ADDITION:**

- BILLS FOR PRIVATE DUTY NURSING SERVICE MUST SHOW THE PROFESSIONAL STATUS OF THE NURSE, SUCH AS R. N. (Registered Nurse)
- BILLS FOR PRESCRIPTION DRUGS MUST SHOW BOTH THE PRESCRIPTION NUMBER AND NAME FOR EACH DRUG
- BILLS FOR DRUGS AND MEDICINES DISPENSED BY A PHYSICIAN MUST SHOW THE NAME OF EACH DRUG OR MEDICINE

ITEMIZED BILLS CANNOT BE RETURNED  
**EXAMPLE OF ITEMIZED BILL**

	Dayton Penridge, M. D. 101 Fourth Street Healthville, U. S. A.	NAME OF THE PERSON OR ORGANIZATION PROVIDING THE SERVICES OR SUPPLIES
NAME OF THE PATIENT RECEIVING THE SERVICES OR SUPPLIES	Joseph Warowes 102 West 35th Street Healthville, U. S. A.  For Professional Services Rendered To: Virginia E. Warowes	
DATE EACH SERVICE OR SUPPLY WAS PROVIDED	7/1/74 Office Care Examination Cortisone Injection 7/2/74 <del>Examination at Home</del> 7/4/74 Physical Therapy	\$XXX XXX XXX XXX  CHARGE FOR EACH SERVICE OR SUPPLY
	DESCRIPTION OF THE SERVICES OR SUPPLIES PROVIDED	PLEASE CROSS OUT THOSE CHARGES WHICH WERE INCLUDED ON A PREVIOUS CLAIM

When the patient is covered under Medicare Hospital Insurance (Part A), the "Notice of Health Insurance Utilization" form furnished by the Social Security Administration (or a mechanical reproduction thereof) pertaining to charges for which benefits are claimed herein must be attached to this claim form. When the patient is covered under Medicare Medical Insurance (Part B), the "Explanation of Benefits" form furnished by the Medicare Carrier (or a mechanical reproduction thereto) pertaining to charges for which benefits are claimed herein must be attached to this claim form.

This completed form, together with itemized bills and supporting material  
should be submitted to

Mutual Medical Plans, Inc.  
P.O. Box 689  
Peoria, IL 61652