CRESCENT HEALTH SOLUTIONS
1200 RIDGEFIELD BLVD. STE. 215
ASHEVILLE, NC 28806

HEALTH CLAIM FORM

SECTION I TO BE COMPLETED BY EMPLOYEE (Please Answer All Questions)

1. Group Number _____ Social Security Number _____

2. Employee's Name _____ Date of Birth _____

3. Employee's Address _____

4. Name of Employer _____ Contact Phone # _____

5. Are you still employed by this Company? ☐ Yes ☐ No
If No, Date Terminated _____

6. Patient's Name _____ Date of Birth _____
Sex ☐ M ☐ F ☐ Single ☐ Married

7. Patient's Relationship to Employee ☐ Self ☐ Spouse ☐ Child (Under 19) ☐ Child (FTS) ☐ Handicapped
☐ Step Child If Step child, does child reside in your home? ☐ Yes ☐ No

8. **OTHER HEALTH INSURANCE** Do you, your spouse, whether married or divorced, or any of your dependent children have any other insurance of the types listed below? (Answer Yes or No to each question.)

Employer	☐ Yes	☐ No	Government Plan	☐ Yes	☐ No	Student School Policy	☐ Yes	☐ No
Union	☐ Yes	☐ No	Association Plan	☐ Yes	☐ No	Any Other Type/Plan	☐ Yes	☐ No

9. If the answer to any of the above is Yes, please complete the following section completely.
Name and Address of Company providing benefits: _____

Insured's Name _____ Date of Birth _____
Social Security # _____ Policy # _____

COMPLETE WHEN AN ACCIDENT IS INVOLVED

Date of accident _____ Location of accident _____
Describe accident in detail _____
Was the accident related to your employment? If Yes explain. _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE ALL DOCTORS, HOSPITALS, OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH CRESCENT TPA SERVICES WITH FULL INFORMATION REGARDING TREATMENT RENDERED (INCLUDING COPIES OF THEIR RECORDS). I ALSO AUTHORIZE CRESCENT TPA SERVICES TO OBTAIN FROM OR RELEASE TO ANY UNION, TRUST FUND, EMPLOYER OR INSURANCE CARRIER ALL INFORMATION REGARDING BENEFITS TO WHICH I, OR ANY OF MY DEPENDENTS MAY BE ENTITLED AND FOR THESE ORGANIZATIONS TO RELEASE TO CRESCENT HEALTH SOLUTIONS, INC. ANY SUCH INFORMATION

SPOUSE'S SIGNATURE
(Only if claim is on spouse or there is other ins)

EMPLOYEE'S SIGNATURE

DATE _____

SECTION II ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER OF SERVICES AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE HOSPITAL, MEDICAL OR PHYSICIAN CHARGES NOT COVERED BY THIS AUTHORIZATION.

☐ Please pay hospital benefits to hospital (bill attached) ☐ Please pay medical and/or surgical benefits to Dr(s).

Date _____ Employee Signature _____

PLEASE BE SURE TO ATTACH ITEMIZED BILLS AND MAIL TO:
Crescent Health Solutions
1200 Ridgefield Blvd., Ste. 215
Asheville, NC 28806