MAJOR MEDICAL
COMPREHENSIVE CLAIM FORM

MAIL TO:
PSERS MAJOR MEDICAL UNIT
P.O. Box 1764
Lancaster, PA 17608-1764
1-800-773-7725

INSTRUCTIONS: **USE THIS FORM FOR CLAIMS INCURRED ON OR AFTER JANUARY 1, 2002.** THIS FORM MUST BE COMPLETED IN FULL. Attach this form to itemized bills for all expenses being claimed. The bills must show: Patient's Name, Type of Service, Date(s) of Service(s), and the Total Charge. If applicable please include the explanation of benefits statement from other insurance coverage, including Medicare. **AVOID DELAY — ANSWER ALL QUESTIONS.**

RETIREE INFORMATION:

GROUP NUMBER: 503

Retiree Name: (Please print first name, middle initial, last name)	Social Security #	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Street Address: (street, city, state, zip code)		Date of Birth: Month/Day/Year

DEPENDENT'S INFORMATION: (complete only if patient is a dependent)

Name of Dependent:	Relationship: ☐ Other (Explain) ☐ Spouse ☐ Child _____	Marital Status (other than spouse):
If claim is for dependent child 19 or older, is child enrolled as a full-time student? ☐ Yes ☐ No	Name of School:	Date of Birth: Month/Day/Year
AT TIME CHARGES WERE INCURRED: (If answer to either is yes, give employer's name and address) Was spouse employed? ☐ Yes ☐ No	If claim was for child, was child employed? ☐ Yes ☐ No	

COMPLETE FOR ALL PATIENTS:

Diagnosis or nature of injury:	
When were you first treated for this condition? (month, day, year)	Name and address of physician who first treated you:

Is patient also covered for benefits by	**Was illness or injury due in any way:**
a. Other Group Health insurance of any kind excluding PSERS Group Health insurance? ☐ Yes ☐ No	a. To the patient's occupation? ☐ Yes ☐ No.
b. Group prepayment arrangement providing for medical care and treatment? ☐ Yes ☐ No	b. To an automobile accident? ☐ Yes ☐ No
c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? ☐ Yes ☐ No	c. To any other type of accident? ☐ Yes ☐ No
d. No fault automobile insurance as a result of injuries sustained in an automobile accident? ☐ Yes ☐ No	
If any of the above are answered YES please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or government agency.	**If any of the above are answered "YES" give details under "Accident".**

Remarks:		
Accident:		
Date:	(Time: ☐ A.M. ☐ P.M.)	(Place of accident: ☐ Work ☐ Other)
How did accident happen?	Name and address where accident occurred:	

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of Medical Benefits to Physician or supplier for services described within.	**SIGNED (PATIENT, OR PARENT IF MINOR)** _____ **DATE** _____
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical information necessary to process this claim.	**SIGNED (PATIENT, OR PARENT IF MINOR)** _____ **DATE** _____