FDFMerge™ HealthCare

(FDFMerge™ Demonstration - Example Healthcare Insurance Claim Form)

Medical Insurance Claim Form

EMPLOYEE INFORMATION:

A. EMPLOYEE ’S NAME (First, M.I., Last)

B. DATE OF BIRTH

C. SEX

D. EMPLOYEE’S MAILING ADDRESS (Street, City, State,Zip) and DAYTIME PHONE #

☐ CHECK IF CHANGE OF ADDRESS

E. EMPLOYEE’S SOC. SEC. / ID NO.

F. MARITAL STATUS

G. POLICY/ACCOUNT NO.

H. DIVISION/BRANCH OR CLASS/LOCATION

I. EMPLOYER

J. EMPLOYEE STATUS

☐ ACTIVE ☐ SALARIED ☐ HOURLY

☐ RETIRED ☐ DISABLED

PATIENT INFORMATION:

A. PATIENT ’S NAME (First, M.I., Last)

B. RELATIONSHIP TO EMPLOYEE

C. SEX

D. DATE OF BIRTH

E. COMPLETE THIS INFORMATION IF PATIENT IS AN UNMARRIED DEPENDANT CHILD

DEPENDANT CHILD IS: ☐ EMPLOYED FULL-TIME ☐ STUDENT FULL-TIME

NAME, ADDRESS AND PHONE # OF CHILD’S SCHOOL/EMPLOYER

ACCIDENT/OCCUPATIONAL CLAIM INFORMATION: