



HEALTHCARE
MANAGEMENT
ADMINISTRATORS

Send claims to: Healthcare Management Administrators, Inc.
P.O. Box 85008, Bellevue, WA 98015
Toll Free (800) 869-7093
Local (425) 462-1000

Baden Sports, Inc.

HEALTH CLAIM FORM

PART 1: Employee Information

EMPLOYEE NAME (Last and First)		EMPLOYEE MONTH	DATE OF BIRTH DAY	YEAR	EMPLOYEE MEMBER ID #	GROUP # <b style="color: blue;">4078
EMPLOYEE ADDRESS	CITY	STATE	ZIP	IS THIS AN ADDRESS CHANGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYEE'S TELEPHONE NUMBER	

MARITAL STATUS SINGLE MARRIED _____ WIDOWED LEGALLY SEPARATED DIVORCED
 NAME OF SPOUSE _____
 IF DIVORCED & CLAIM IS FOR DEPENDENT CHILD, ANSWER THE FOLLOWING QUESTIONS: A) IS THIS CHILD IN YOUR PERMANENT CUSTODY? YES NO
 B) IS THERE A COURT ORDER FOR PROVISION OF MEDICAL CARE FOR THIS CHILD? YES NO

PART 2: Patient Information

PATIENT NAME		IS PATIENT <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER IF OTHER, SPECIFY _____
PATIENT'S DATE OF BIRTH MONTH DATE YEAR	IF CLAIM IS FOR DEPENDENT OVER AGE 19, IS THE DEPENDENT A FULL TIME STUDENT? IF SO, PLEASE PROVIDE PROOF OF STUDENT STATUS.	

PART 3: Description of Claim

DESCRIBE ILLNESS OR INJURY:	WORK RELATED ILLNESS OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DID YOU OR WILL YOU BE FILING A CLAIM WITH L&I? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF CLAIM IS DUE TO ACCIDENT STATE WHEN, WHERE AND HOW THE ACCIDENT OCCURRED:
HAS PATIENT BEEN TREATED FOR THIS ILLNESS OR INJURY WITHIN THE PAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE OF SERVICE: _____	IF YES, NAME AND ADDRESS OF ATTENDING PHYSICIAN REFERRING PHYSICIAN IF APPLICABLE _____	

PART 4: Other Group Health Insurance

ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED BY OTHER INSURANCE FOR MEDICAL, DENTAL, OR VISION BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO CHECK ONLY THOSE COVERED BY OTHER GROUP INSURANCE.: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE DATE OF BIRTH _____ <input type="checkbox"/> DEPENDENT(S) LIST THE DEPS. _____ _____ _____	NAME AND ADDRESS OF OTHER INSURANCE CARRIER: POLICY NUMBER: _____ EFFECTIVE DATE: _____
IS PATIENT ELIGIBLE FOR MEDICARE BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ENTER DATE OF ELIGIBILITY _____ SOCIAL SECURITY NO. _____	

PART 5: Complete for all claims

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING FALSE INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

EMPLOYEE SIGNATURE _____ DATE _____

PART 6: Claims Benefit Assignment and Authorization

SIGN HERE IF YOU WISH PAYMENT TO BE MADE TO YOU, OTHERWISE IT WILL GO TO THE PROVIDER OF CARE., _____ DATE _____
SIGNED (BY EMPLOYEE)

AUTHORIZATION TO RELEASE INFORMATION: I expressly authorize any provider of care to furnish, any records concerning me or any Member of my family for whom benefits or services has been claimed. _____ DATE _____
SIGNED (BY PATIENT, OR PARENT, IF MINOR)