PATIENT ADVOCATES
THE WAY HEALTHCARE SHOULD BE

MEDICAL CLAIM FORM

Name	ID Number
Address (Street)	Employer
Address (City,State,Zip)	Group Number

Expense For			Dates of Service		Procedure Code	Diagnosis Code	Amount Due
First Name	Age	Relationship	From	To			

EMPLOYEE SIGNATURE: ______________________________ DATE: ______________

*****PLEASE ATTACH A COPY OF THE BILL AND/OR EXPLAINATION OF BENEFITS*****