**SUBMIT ALL CLAIM TO** **Capitol Administrators, Inc., P.O. Box 2318**
**Rancho Cordova, CA 95741-2318**
**For Information call (800) 331-5301**

*IMPORTANT INSTRUCTIONS*

- **USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY AND FOR EACH DIFFERENT PROVIDER OF SERVICE (DOCTOR, DENTIST, LAB, ETC.)**
- **TYPE OR PRINT ALL INFORMATION**
- **FILL IN ALL ITEMS COMPLETELY (WHERE APPLICABLE)**
- **SIGN AND DATE THE FORM IN THE SPACES PROVIDED**
- **IF CAPITOL IS YOUR SECONDARY INSURANCE, ATTACH A COPY OF THE EXPLANATION OF BENEFITS (EOB) FROM YOUR PRIMARY CARRIER**
- **ATTACH THE ORIGINAL ITEMIZED BILL(S) FOR THE SERVICES OF THIS PROVIDER (WE CANNOT ACCEPT 'BALANCE STATEMENTS', CASH REGISTER OR CREDIT CARD RECEIPT(S)**

EMPLOYER'S NAME

| NAME OF EMPLOYEE | DATE OF BIRTH (Month, day, year) | SEX |
|---|---|---|
| | | |

| HOME ADDRESS STREET OR P.O. BOX NUMBER | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| EMPLOYEE'S SOCIAL SECURITY NO. | OCCUPATION | ❑ MARRIED ❑ SINGLE ❑ WIDOWED ❑ DIVORCED |
|---|---|---|
| | | |

| NAME OF SPOUSE | DATE OF BIRTH (Month, day, year) | IS YOUR SPOUSE EMPLOYED? ❑ YES ❑ NO | IF YES, NAME AND ADDRESS OF EMPLOYER |
|---|---|---|---|
| | | | |

| IS THE PATIENT, OR ANY FAMILY MEMBER ENROLLED IN AN HMO, PPO OR COVERED UNDER ANY MEDICAL, DENTAL OR OTHER GROUP INSURANCE PLAN ❑ YES ❑ NO | IF YES, GIVE NAME AND ADDRESS OF HMO, PPO FACILITY, EMPLOYER OR OTHER GROUP INSURANCE CO. |
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## DEPENDENT INFORMATION

| IS CLAIM FOR DEPENDENT? ❑ YES ❑ NO | NAME OF DEPENDENT, IF OTHER THAN SPOUSE | DEPENDENT'S RELATIONSHIP TO EMPLOYEE |
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| DEPENDENT'S DATE OF BIRTH (Month, day, year) | IF DEPENDENT IS A FULL-TIME STUDENT, GIVE NAME AND ADDRESS OF SCHOOL |
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| | |

## PATIENT & INSURED (SUBSCRIBER) INFORMATION

| 1. PATIENT'S NAME (First name, middle initial, last name) | 2. PATIENT'S DATE OF BIRTH | 3. INSURED'S NAME (First name, middle initial, last name)E |
|---|---|---|
| | | |

| 4. PATIENT'S ADDRESS (Street, City, State, Zip code) | 5. PATIENT'S SEX ❑ M ❑ F | 6. INSURED'S I.D., MEDICARE AND OR MEDICAID NO. (Include any letters) |
|---|---|---|
| | 7. PATIENT'S RELATIONSHIP TO INSURED | INSURED'S GROUP NO. (or Group Name) |
| | | |

| 9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder, Plan Name, address and policy number | 10. WAS CONDITION RELATED TO: ❑ PATIENT'S EMPLOYMENT ❑ AN AUTO ACCIDIENT | 11. INSURED'S ADDRESS (Street, City, State, Zip Code) |
|---|---|---|
| | | |

12 - 13

I certify the above is complete and correct and I am claiming benefits only for charges by the patient named above.

Authorization is hereby given to any hospital, physician, or other provider which participated in any way with the care and treatment, or insurance company prepaid health plan, employer or group policyholder, contract holder or benefit plan administrator to release to the above Plan Administrator any medical information and any employment information regarding the patient, which they in their judgment deem necessary to evaluate and administer claim benefits. This authorization is valid for the duration of the claim.

I know I have a right to receive a copy of this authorization and that its photographic copy is as valid as the original.

| **SIGNATURE** (Insured or Authorized Person) | DATE |
|---|---|
| | |

**NOTE: IF YOU HAVE A DOCTOR'S BILL CONTAINIGN THE INFORMATION REQUESTED BELOW, YOU MAY ATTACH IT TO THIS FORM RATHER THAN COMPLETING THE FORM ITSELF.**

**AUTHORIZATION TO PAY PROVIDER:** I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE PROVIDER OF ANY BENEFITS OTHERWISE PAYABLE TO ME UNDER THIS PLAN

| **SIGNATURE** (Insured or Authorized Person) | DATE |
|---|---|
| | |

## PHYSICIAN OR SUPPLIER INFORMATION

| 14. DATE OF 1ST SYMPTOM-ACCIDENT | 15. DATE FIRST CONSULTED YOU FOR THIS CONDITION | 16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS |
|---|---|---|
| | | |

| 17. DATE(S) OF TOTAL DISABILITY<br>FROM THROUGH | 18. DATE PATIENT ABLE TO RETURN TO WORK |
|---|---|
| | |

| 19. NAME OF REFERRING PHYSICIAN OR FACILITY | 20. FOR SERVICES RELATED TO HOSPITALIZATION<br>DATE ADMITTED DATE DISCHARGED |
|---|---|
| | |

| 21. NAME AND ADDRESS OF FACILITY | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ❑ YES ❑ NO | CHARGE<br>$ |
|---|---|---|
| | | |

23. DIAGNOSIS (ICD-9-CM) (IF MORE THAN ONE CONDITION, PLEASE RELATE DIAGNOSIS TO PROCEDURE(S) USING ICD-9-CM CODE(S) TO FIFTH DIGIT IF APPLICABLE)

| IF MORE THAN ONE CONDITION, PLEASE RELATE DIAGNOSIS TO PROCEDURE(S) USING ICD-9-CM CODE | PLACE OF SERVICE CODE | IH – INPATIENT HOSPITAL<br>OH – OUTPATIENT HOSPITAL<br>O – DOCTOR'S OFFICE | H – PATIENT'S HOME<br>NH – NURSING HOME<br>SNK – SKILLED NURSING FACILITY | OL – OTHER LOCATIONS<br>IL – INDEPENDENT LABORATORY |
|---|---|---|---|---|

| DATE OF SERVICE | DIAGNOSIS CODE | PLACE OF SERVICE | DESCRIPTION OF PROCEDURES | PROCEDURE CODE (CPT-4) | CHARGE |
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| PHYSICIAN'S OR SUPPLIER'S NAME | | | SOCIAL SECURIY NO. | TOTAL CHARGE<br>$ |
|---|---|---|---|---|
| STREET ADDRESS | | | EMPLOYER TAX IDENTIFICATION NO. | AMOUNT PAID<br>$ |
| CITY | STATE | ZIP CODE | **TELEPHONE NUMBER**<br>( ) | BALANCE DUE<br>$ |

| SIGNATURE OF PHYSICIAN OR SUPPLIER | DATE |
|---|---|
| | |