



GROUP EXCESS MEDICAL

In-Hospital Statement of Claim



**TO FILE: ATTACH COPIES OF PAYMENT STATEMENTS FROM ALL OTHER CARRIERS.
MAIL TO: Fitzharris & Co., Inc., P.O. Box 9182, Farmingdale, NY 11735 (516) 777-2244**

PART 1 TO BE COMPLETED BY INSURED

Name _____ Employed By _____

Address: _____ Town, State: _____

Birth Date _____ Sex _____ SS# _____

Admission Date: _____ Discharge Date: _____

I authorize any individual of organization to release any information to First Rehabilitation Life Insurance Company of America for any services or benefits received or payable to me or on my behalf.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Eligible Insured _____ Date _____

PART 2 TO BE COMPLETED BY HOSPITAL IN LIEU OF BC / BS VOUCHER

1. Name of Hospital _____

Location _____

2. Patient _____ Hospital No. _____
Last Name First Name Middle Name

Age _____ Sex _____ If Minor, Name of Guardian _____

3. Admitted (Date) _____ Discharge (Date) _____

Total Days Hospitalized _____

4. Was patient in Intensive Care Unit during hospitalization? _____ Yes _____ No

If yes, furnish dates of such I.C.U. confinement

From _____ To _____

5. If patient is still hospitalized, please indicate expected duration of current hospitalization. _____

6. Diagnosis: _____

Date: _____ 19 _____
Medical Records Librarian or Authorized Designee _____

PART 3 TO BE COMPLETED BY: (BENEFITS ADMINISTRATOR)

Name _____ Group # _____

Effective Date: _____ Term Date: _____

_____ Date: _____