TBR
Taylor Benefit Resource

COLQUITT REGIONAL
MEDICAL CENTER

164 Commercial Drive.
P. O. Box 6580
Thomasville, GA 31758
1 888 35-CLAIM
229 225-9943
Fax (229) 225-9945

Medical Claim Form - Employee's Statement: To be completed by the Employee

A. About You

Name of Employee	Date of Birth	__ Single __ Divorced __ Married __ Widowed __ Legally Separated
Address	Soc. Sec. No.	
City, State & Zip	Place of employment:	

B. About Your Spouse

Name of Employee's Wife or Husband	Name & Address of Spouse's Employer
Does his or her employer provide a group Insurance Plan? ___ Yes ___ No	If yes, is the patient for this claim covered by that plan ? ___Yes ___ No

C. About The Patient

This Claim Is For:

___ Myself
___ My Spouse: Name _____Age _____

___ My Child: Name _____ Age_____
Is Child Employed? ___ Yes ___ No Is Child a Full-Time Student? ___Yes ___ No
Name/Address of Employer/School:_____

D. About The Claim

This Claim is Due to:

(complete one of these sections)

An Injury

Date _____ Where did it occur?_____
How did it happen?_____
_____
Was the accident connected with Patient's Employment ___ Yes ___No

A Sickness

When did Symptoms begin? _____
Name of Doctor_____

E. About The Other Insurance

Is the patient covered by one or more of the following (include Insurance Carried by Husband/Wife or other dependent)

A. Any Group Insurance, or any Medical Plan because of Membership in a Group..... _____Yes _____No
B. Any Group Blue Cross, Blue Shield, or Other Similar Plan?..... _____Yes _____No
C. Any Federal, State, or other Governmental Plan, or Union Welfare Plan?..... _____Yes _____No
D. Any Medical Plan Sponsored by a School or College?..... _____Yes _____No
E. Is There Coordination of Benefits Provisions in the Other Group Insurance Plan?..... _____Yes _____No

If the answer to any of the above is "YES" , Please give complete information about the Plan(s) below:

Name & address of the Insurance Company	Name of Employer, Group, or School Providing the Plan	Name of the Insured Person	Policy Number

The statements above are true and correct to the best of my belief. I Authorize any Hospital or Physician to furnish Administrative Claim Service any information requested. Also, I hereby Authorize my Employer or Administrative Claim Service to release to or obtain from any organization, or person or regulatory agency any information which may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

_____

Employee's Signature Date

MAIL TO:

Taylor Benefit Resource, Inc.
P. O. Box 6580
Thomasville, GA 31758
888-35-CLAIM
Payor ID: 65800