**BENEFIT REQUEST FORM**
TYPE OR PRINT

Submit To: Key Benefit Administrators, Inc.
P.O. Box 2050
Fort Mill, SC 27916-2050

KEY BENEFIT ADMINISTRATORS, INC.

## PATIENT INFORMATION (TO BE COMPLETED BY EMPLOYEE)

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. EMPLOYEE'S NAME AND ADDRESS

FULL TIME STUDENT
☐ YES ☐ NO IF YES, WHERE

4. PATIENT'S ADDRESS *(if different from employee)*

5. PATIENT'S SEX
☐ MALE ☐ FEMALE

6. EMPLOYEE'S SOC. SEC. NO.

7. PATIENT'S RELATIONSHIP TO INSURED
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

8. GROUP NAME *(e.g. employer)*

9. OTHER HEALTH INSURANCE COVERAGE
☐ YES ☐ NO
If yes, Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
☐ YES ☐ NO
B AN ACCIDENT
☐ YES ☐ NO

11. IF AN ACCIDENT
date_____20_____and time_____ ☐ AM ☐ PM
description (how & where) _____

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
*I authorize the Release of any Medical Information Necessary to Process this request.*

SIGNED: DATE:

13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.*

*SIGNED (Employee or Authorized Person)*

## PHYSICIAN OR SUPPLIER INFORMATION (TO BE COMPLETED BY PHYSICIAN AND RETURNED TO EMPLOYEE)

14. DATE OF:

**ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)**

**15. DATE FIRST CONSULTED YOU FOR THIS CONDITION**

**16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?**
☐ **YES** ☐ **NO**

17. DATE PATIENT ABLE TO RETURN TO WORK

**18. DATES OF TOTAL DISABILITY**
**FROM** **THROUGH**

**DATES OF PARTIAL DISABILITY**
**FROM** **THROUGH**

19. NAME OF REFERRING PHYSICIAN

**20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES**
**ADMITTED** **DISCHARGED**

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

**22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?**
☐ **YES** ☐ **NO**
**CHARGES:**

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATED TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.
2.
3.
4.

| 24. A DATE OF SERVICE | B PLACE OF SERVICE | C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN | | D DIAGNOSIS CODE | E CHARGES | F |
|---|---|---|---|---|---|---|
| | | PROCEDURE CODE (IDENTIFY: ) | *(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)* | | | |
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25. SIGNATURE OF PHYSICIAN OR SUPPLIER

SIGNED DATE

26.

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

30. YOUR SOC. SEC. NO.

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. YOUR EMPLOYER ID NO

*PLACE OF SERVICE CODES
1-(IH)-INPATIENT HOSPITAL
2-(OH)-OUTPATIENT HOSPITAL
3-(O)-DOCTOR'S OFFICE
4-(H)-PATIENT'S HOME
5- DAYCARE FACILITY (PSY)
6- NIGHT CARE FACILITY (PSY)
7-(NH)-NURSING HOME
8-(SNF)-SKILLED NURSING FACILITY
9- AMBULANCE
O-(OL)-OTHER LOCATIONS
A-(IL)-INDEPENDENT LABORATORY
B- OTHER MEDICAL/SURGICAL FACILITY

***PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY**