

# CLAIM FOR HOSPITAL AND OTHER MEDICAL EXPENSES

▶ If illness or injury occurred while at work, contact the Workers Compensation Insurance Representative, ext. 30807, BEFORE filling out this form.

PART I - TO BE COMPLETED BY STAFF MEMBER OR RETIRED STAFF MEMBER (hereinafter: staff member) OR PATIENT IF COVERED SEPARATE FROM STAFF MEMBER				
1. Patient's Name (Last, First, M.I.)		2. Patient's Relationship to Staff Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child <input type="checkbox"/> Dependent Parent		3. Patient's Birthdate Month   Day   Year
4. Sex <input type="checkbox"/> M <input type="checkbox"/> F				
5. If claim is for son/daughter, was a Dependency (Tax Equivalency) Allowance payable at the time the expense was incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No. If No, please answer questions A and B below.				
A. Is he/she married? <input type="checkbox"/> Yes <input type="checkbox"/> No B. If over 18, is he/she a full time student & dependent upon you for support & maintenance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
6. Staff Member's (or Surviving Spouse's) Name (Last, First, M.I.) <i>IF NOT PATIENT</i>		7. Staff Member's (or Surviving Spouse's) Birthdate <i>IF NOT PATIENT</i>		8. UPI No.
9. Nature of illness, injury or service				
10. If claim is for accidental injury, enter date and indicate where and how it occurred				11. Is claim for second surgical opinion? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Is patient, other than <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Employee name? staff member, employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		13. Name and Address of Employer in Item 12.		
14. Is patient covered by another group, student, government (e.g. Medicare) or employment related Medical Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No, If Yes, enter: Medical Plan Name   Group No.   Name & Address of Carrier				
<p>I authorize the release to the World Bank Group Medical Insurance Plan administrator, to the World Bank Group or their representative, any information including medical, employment and benefit information required for claim processing or plan administration. Such information shall be released directly to the World Bank Group only in circumstances where fraud or misconduct is believed to have occurred. This authorization to release information is valid for two years after the date signed. A copy of this authorization shall be as valid as the original. If the staff member is incapacitated or deceased, the Personal Representative or next of kin must sign.</p> <p>Patient's Signature (Parent/Guardian, if minor; leave blank if staff member) _____ Date _____</p> <p>I certify that the statements here and attached are complete and accurate. As the patient, I authorize the release of information as described above.</p> <p>Staff Member's Signature _____ Date _____</p>				
PART II - TO BE COMPLETED BY ATTENDING PHYSICIAN (in lieu of itemized bill)				
15. Physician's Name		17. Is treatment result of occupational illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, enter brief description and dates		
16. Mailing Address (Street, City, State, ZIP)		18. Date symptoms first appeared or accident happened?		
19. Physician's S.S.N. or T.I.N.	20. Physician's License No.	21. Physician's Telephone No.	22. Date you were first consulted on this condition?	
23. Diagnosis and current condition				
24. Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No, If Yes, indicate when and describe				
25. Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date of Service	Place	ICD-9 Code	Description	Charge
26. I certify that the procedures as indicated by date have been completed Signature _____ Date _____				
<p><b>Return completed form to:</b>  <b>Aetna/World Bank MIP Claims P.O. Box 14199 Lexington, KY 40512-4199 USA OR via internal mail to MIP claims MSN MC-C3-309.</b></p>				