Please send completed form to:

Claims Management Corporation
Post Office Box 419797
Kansas City, Missouri 64141
Telephone: 1-800-821-5401
Fax: 1-866-486-5243

TRUCKER OCCUPATIONAL ACCIDENT PLAN MEDICAL CLAIM FORM

CMC

PLEASE COMPLETE ONE CLAIM FORM PER ACCIDENT

1. Claimant Information

A. Trucking Company Information

Trucking Company Affiliation

B. Claimant's Information

Last Name	First Name	Initial	Social Security No. ___ - ___ - ___
Home Address			Birth Date Month / Day / Year Male ☐ Female ☐
City	State	Zip	Telephone No. ___ - ___ - ___

2. Other Insurance

C. Complete if you are covered under any other medical plan

Other Plan Name Identification Policy No.

Insurance Company Name and Address

City State Zip

3. Accident Details

D. Give Complete Accident Details

Is claim due to an accident? If "yes," where did the accident occur?
Yes ❒ No ❒

Date of Accident? Month / Day / Year

Describe Accident – What happened?

Is the claim the result of:
A work related injury? Yes ❒ No ❒
Auto Accident? Yes ❒ No ❒

4. Assignment of Benefits

E. Complete only if you wish payment to be made directly to doctor, hospital or other medical service provider

Name of Doctor, Hospital or Other Medical Service Provider

City State Zip

Telephone Number Provider's I.D. Number

Signature Authorizing Assignment of Benefits Date Month / Day / Year

5. Must be signed and date by Claimant

F. Read and complete authorization to release medical and insurance information.

To any physician, medical practitioner, hospital, clinic or other medically related facility or provider of medical services or supplies, and any group policyholder or insurer, I authorized you to release to Claims Management Corporation or its representatives any and all information you may have about the mental and physical history, condition and treatment and insurance coverage for the Claimant named in Section B above. I further authorize any company to release any driving or business records to Claims Management Corporation.

I understand the information obtained by Claims Management Corporation will be used for the purpose of evaluating and administering a claim for benefits. Any information obtained will not be released by Claims Management Corporation to any person or organization EXCEPT to reinsuring companies, Medical Information Bureau, Inc. Group Policyholder, or other persons or organizations performing business or legal services in connection with my Claim, or as may be otherwise lawfully required as I may further authorize. For the purpose of disclosing information, I understand this authorization is given in connection with a claim for medical benefits, disability or life insurance benefits. I understand that it is valid for the duration of the claim. A photocopy of this authorization shall be as valid as the original.

Claimant's Signature Date Month / Day / Year

6. PHYSICIAN COMPLETE THE REVERSE SIDE.

For your protection, California law requires the following to appear on this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

TO BE COMPLETED BY PHYSICIAN OR OTHER PROVIDER OF MEDICAL SERVICES

Please complete the following information or attached itemized bills, receipts and statements of change from all physicians, hospitals and any other source. These statements must contain the following:

A. Patient's name
B. All services or supplies provided.
C. The charge for each service provided.
D. The date each service or supply was provided.
E. Diagnosis or illness involved.

PHYSICIAN OR SUPPLIER

Date of Illness (First Symptom) or Injury (Accident)	Date First Consulted You For This Condition	Has patient ever had same or similar symptoms? Yes ❒ No ❒

Date Patient Able to Return to Work	Dates of Total Disability From Through	Dates of Partial Disability From Through

Name of Referring Physician	For Services related to hospitalization give hospitalization dates Admitted Discharged

Name and address of facility where services rendered (if other than home or office)	Was laboratory work performed outside your office? Yes ❒ No ❒ Charges
	Are the services rendered covered by any other group plan? Yes ❒ No ❒
	If yes: Group Number:
	Insurance Company Name and Address:

Diagnosis or nature of illness or injury.	Was this illness or injury due to an accident? Yes ❒ No ❒
1 2 3 4	Was this illness or injury work related? Yes ❒ No ❒

Date of Service	Place of Service *	Procedure Code CPT 4	Fully describe procedure, medical service or supplies furnished for each date given (Explain unusual services or circumstances)	ICD9 Diagnosis Code	Charges	

Signature of Physician or Supplier	Accept Assignment Yes ❒ No ❒	Total Charge	Amount Paid	Balance Due
Signed Date		Physician's or Supplier's Name, Address, Zip Code, Telephone No.		
Your Patient's Account No.		I.D. No.		

* Place of Services Codes

1-(H) - Inpatient Hospital	4-(H) - Patient's Home	7-(NH) - Nursing Facility	O-OL - Other Locations
1-(OH) - Outpatient Hospital	5- - Day Care Facility (PSY)	8-(SNF) - Skilled Nursing Facility	A-IL -Independent Laboratory
3-(O) - Doctor's Office	6- - Night Care Facility	9- -Ambulance	B- - Other Medical/Surgical Facilities

PRESCRIPTION DRUGS

Complete each column for each prescription	Date of Purchase	Prescription Number	Name of Medication	Diagnosis for which Medicine was Prescribed	Prescribing Physician	Cost (Excluding Tax)