PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

FORM APPROVED
OMB NO. 0938-0008

☐ MEDICARE (MEDICARE NO.)	☐ MEDICAID (MEDICAID NO.)	☐ CHAMPUS (SPONSOR'S SSN)	☐ CHAMPVA (VA FILE NO.)	☐ FECA BLACK LUNG (SSN)	☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO.	5. PATIENT'S SEX MALE ☐ ☐ FEMALE	6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS)
	7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.) ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (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. ACCIDENT AUTO ☐ ☐ OTHER	11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO. 11a. CHAMPUS SPONSOR'S: STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. SIGNED DATE		13. I AUTHORIZE THE RELEASE OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES	16a. IF EMERGENCY CHECK HERE ☐
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 OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ ☐ NO CHARGES:	

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

1.
2.
3.
4.

B.
EPSDT YES ☐ ☐ NO
FAMILY PLANNING YES ☐ ☐ NO

PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B.* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* TOS	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF) DATE:	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ ☐ NO	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.	I.D. NO.		

* PLACE OF SERVICE AND TYPE OF SERVICE (TOS)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form **HCFA-1500 (1-84) (C-2)**
Form **CHAMPUS-501**
Form **OWCP-1500**
Form **RRB-1500**

MAIL TO
ABA , Inc.
P.O. Box 10787
Burbank, CA 91510-0787
1 (800) 350-0148

MEDICAL CLAIM

EMPLOYEE'S INSTRUCTIONS FOR FILING A CLAIM

YOUR CLAIM WILL BE SUBJECT TO DELAY OR MAY BE RETURNED IF THESE INSTRUCTIONS ARE NOT FOLLOWED. USE A SEPARATE FORM FOR EACH MEMBER OF THE FAMILY AND FOR EACH SEPARATE ILLNESS OR ACCIDENT. ADDITIONAL BILLS FOR THE SAME PERSON MAY BE SUBMITTED COMPLETING ***ONLY*** THE EMPLOYEE SECTION OF THE CLAIM FORM.

Complete every applicable entry on this form.

Have the reverse side of this form completed by your primary attending physician. Ask other providers of service to give you an **ITEMIZED BILL**. Receipts and cancelled checks are not acceptable.

TO BE COMPLETED BY THE EMPLOYEE

A. Employee's name _____ ❑ Male ❑ Female Date of Birth _____

B. Street Address _____ City _____ State _____ Zip code _____

C. Employer name and address _____ Date hired _____

D. Have you terminated employment? ❑ Yes ❑ No If yes, date _____ Social Security # _____

E. Marital Status _____ Name of spouse _____ Is spouse employed? ❑ Yes ❑ No

F. Name and address of spouse's employer _____

G. Is condition work related? ❑ Yes ❑ No Have you filed for Worker's Compensation benefits? ❑ Yes ❑ No

H. Is condition related to accident or injury? ❑ Yes ❑ No Date first symptoms of illness or injury appeared _____

I. If yes to G or H, please give detailed description _____

_____

J. Have you/dependent previously been treated for this or a related medical problem? ❑ Yes ❑ No
If yes, state when and give name(s) of doctor(s) and hospital(s)

_____

K. Are you or any of your dependents entitled to benefits under any other group plan? ❑ Yes ❑ No

If yes, give name of: Employer: _____

Person carrying other coverage _____

Insurance company _____

Policy number _____ Social Security Number _____

Address of Claims Paying Office _____

COMPLETE THE FOLLOWING QUESTIONS ONLY IF CLAIM IS FOR A DEPENDENT

L. Dependent's 's name _____ Date of Birth _____ Relationship _____

M. Is the child 19 years old or older? ❑ Yes ❑ No If so, is (s)he a full-time student ❑ Yes ❑ No

Name of school _____ Marital Status _____

AUTHORIZATION

Upon presentation of this original or a photocopy thereof, I authorize any medical professional, medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide Affordable Benefit Administrators, Inc. or any agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, with all information regarding advice, care treatment and diagnosis about any medical condition, including use of drugs or alcohol concerning the patient herein. I also authorize any patient's or member's employer, group policyholder or benefit plan administrator to provide Affordable Benefit Administrators, Inc., or the above-named parties with all other medical or employment information relevant to this claim. I understand that Affordable Benefit Administrators, Inc. will use such information for evaluation and administration of claims for insurance benefits; I have a right to receive a copy of this authorization upon request; and this authorization is valid from the date signed for the duration of the claim. I certify the information given by me is true and correct.

EMPLOYEE'S SIGNATURE	DATE	PATIENT'S SIGNATURE (Guardian to sign if parent is under age 15)	DATE