

United Security Health & Casualty

Security Access Plan

Claim Form



UNITED SECURITY
 HEALTH AND CASUALTY INSURANCE COMPANY
 6640 S. Cicero Ave., Bedford Park, IL 60638
 (800) 875-4422 · www.ushandc.com

INSTRUCTIONS

Please type or print. The form must be completed in full and signed. Indicate "N/A" if item does not apply. **Return completed form along with an itemized provider statement (bill).** The statement must be prepared by the provider and include:

1. Patient name and date of service
2. A list of service(s) performed (CPT codes preferred) and the charge for each service
3. The diagnosis (ICD9 codes preferred)
4. The provider name, Federal Tax Identification Number (FEIN or TIN), and contact information

*** You must notify us of the claim within 60 calendar days after the date the covered event occurs or as soon as reasonably possible.**

SECTION 1 - POLICYHOLDER INFORMATION

Name (Last, First, Middle Initial)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security Number	Date of Birth	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Street Address		City	State Zip Code + 4
Policy Number			

SECTION 2- PATIENT'S INFORMATION

Name (Last, First, Middle Initial)	Date of Birth	Social Security Number
Relationship to Policyholder <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other _____		Date of Accident
Did this accident/illness occur at work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you want benefits Paid directly to the provider(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of service on bills submitted: Earliest Date _____ Last Date _____		

Report of Services: (attach itemized bill)

Date of Service	Description of surgical or medical services received

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician and/or Hospital providing services for which benefits are payable. This assignment will be honored only when the claim form from the provider of services does not contain any assignment of benefits or an indication that it is on file.

 Signature of Patient (if minor, parent/guardian must sign)

 Date