LOS ANGELES FIREMEN'S
RELIEF ASSOCIATION

MEDICAL CLAIM FORM AND AUTHORIZATION

SUBMIT YOUR COMPLETED CLAIM FORM ALONG WITH THE ITEMIZED BILL AND PROOF OF PAYMENT* TO HEALTHCOMP.

MAIL
P.O. BOX 45018
Fresno, CA 93718-5018

FAX
(559) 499-2464

ONLINE
hconline.healthcomp.com/lafra

MEMBER INFORMATION

1. NAME OF MEMBER **(PRIMARY SUBSCRIBER, SURVIVING SPOUSE, OR SURVIVING DOMESTIC PARTNER)** LAST, FIRST, MIDDLE	2. MEDICAL ID or SOCIAL SECURITY NUMBER

3. MEMBER ADDRESS - STREET	CITY	STATE	ZIP	DATE OF BIRTH

COMPLETE SECTION 4 IF THE CLAIM IS FOR YOUR SPOUSE, DOMESTIC PARTNER OR DEPENDENT

4. NAME OF SPOUSE, DOMESTIC PARTNER OR DEPENDENT	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH	SOCIAL SECURITY NUMBER

5. (A) ARE YOU OR ANY MEMBER OF YOUR FAMILY COVERED UNDER MEDICARE? ☐ YES ☐ NO
(B) ARE YOU OR ANY MEMBER OF YOUR FAMILY COVERED UNDER ANOTHER GROUP PLAN PROVIDING MEDICAL BENEFITS? ☐ YES ☐ NO

REMARKS: **IF YOU HAVE CHECKED *YES* TO ANY OF THE ABOVE, PLEASE PROVIDE THE POLICY NUMBER:**

NAME OF COVERED PERSONS:

EFFECTIVE DATE:

NAME OF OTHER GROUP PLAN:

ADDRESS - STREET: CITY: STATE: ZIP:

NAME OF THE EMPLOYER, (SCHOOL, UNION) OR ORGANIZATION WHICH SPONSORS THE COVERAGE:

ADDRESS - STREET: CITY: STATE: ZIP:

IF YOU ARE COVERED BY MEDICARE, OR ANY OTHER PLAN SUCH AS BLUE CROSS – BLUE SHIELD, PLEASE SUBMIT THE CARRIER'S PAYMENT STATEMENTS, EXPLANATION OF BENEFITS, OR DECLINATION ALONG WITH ITEMIZED BILLS.

COMPLETE FOR ACCIDENT ONLY

6. THIS CLAIM IS FOR: ☐ MEMBER ☐ SPOUSE OR DOMESTIC PARTNER ☐ DEPENDENT

7. ☐ ACCIDENT / INJURY DATE: TIME:

BRIEFLY DESCRIBE THE ACCIDENT/INJURY:

DOES THIS CLAIM INVOLVE A WORK-RELATED ACCIDENT/INJURY? ☐ YES ☐ NO

8. AUTHORIZATION TO RELEASE INFORMATION:

The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, health care provider, practitioner or other person, any employer, any hospital, including veterans administration or government hospital, any medical service organization, any insurance company, health plan payor or any other institution or organization (including, but not limited to, LAFRA) to release to each other and to (or by) LAFRA (and its representatives, including, but not limited to, HealthComp) any medical or other information (including, but not limited to, information relating mental health, alcohol or substance abuse treatment) acquired, including, but not limited to, benefits paid or payable, concerning this claim or any related claims. Any such released information may be used for any activity in connection with the administration of this (or any related) claim, including, but not limited to, review by LAFRA of any appeal of a denial of this claim. A Photostat of this authorization shall be as valid as the original. This authorization shall remain in effect for the duration of this claim or if later, the duration of the coverage under the Plan for person on whose behalf this claim is being made.

Signature (Patient or Parent if Minor) Date

9. ASSIGNMENT OF, AND AUTHORIZATION TO PAY, BENEFITS:

The person, on whose behalf this claim is being made, hereby assigns his or her rights to benefits under the LAFRA group health plan (the "Plan") and authorizes payment directly to the provider, named in the attached itemized bill (the "bill"), for those benefits to which such person is entitled under the Plan with respect to the bill.

Signature (Patient or Parent if Minor) Date

*** ITEMIZED BILL SHOULD INCLUDE MEMBER NAME AND ID, DATE OF SERVICE, DIAGNOSIS CODES, CPT CODES, BILLED CHARGE FOR EACH CPT BILLED, AND THE PROVIDER'S NAME, ADDRESS AND TAX ID. PROOF OF PAYMENT CAN BE A CANCELLED CHECK, A RECEIPT FROM THE PROVIDER'S OFFICE, OR A BANK STATEMENT SHOWING PAYMENT AMOUNT.**