



**AMERICAN
STERLING**

MEDICAL CLAIM FORM

Send Claims To:
AMERICAN STERLING INSURANCE SERVICES, INC.
P O BOX 26103
OVERLAND PARK, KS 66225-6103

Instructions:

1. Please complete all sections
2. All itemized bills MUST be attached and include: Patient's name, Provider's name, diagnosis, date of service and charge amount.
3. If you or a dependent are covered by another plan (including MEDICARE), please submit the bill to the Primary Plan first. Then send our office a copy of the Explanation of Benefits along with the bill.

EMPLOYEE INFORMATION

Name (First, MI, Last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Social Security Number
Home Street Address		City	State	Zip Code
Employer	Date of Hire	Occupation	Date Last Worked	

PATIENT INFORMATION

Patient Name (First, MI, Last)		Relationship	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate
Is the Patient Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the Patient a Full-Time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, How many hours?	Date Last Attended?	Name and Address of School
Nature of Illness		Name, Address and Phone No. of Doctor Seen For this Illness		

IF CLAIM IS BASED ON AN ACCIDENT, COMPLETE THE FOLLOWING

Date and Time of Accident	Was Accident Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where and How it Happened
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AUTHORIZATION TO RELEASE INFORMATION –
I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to American Sterling Insurance Services, Inc. for any oral or dental observation, treatment, Services, or benefits rendered or payable to me or on my behalf. A Photocopy of this authorization shall be valid as the original.

PATIENT'S SIGNATURE (PARENT IF MINOR) DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS
I hereby authorize payment of benefits to any providers of service Rendered or payable to me or on my behalf. A photocopy of this Authorization shall be valid as the original.

PATIENT'S SIGNATURE (PARTENT IF MINOR) DATE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I CERTIFY THAT THIS INFORMATION IS COMPLETE AND ACCURATE TODAY'S DATE _____

(Insureds Signature)

(Patient's Signature if Dependent Adult)