

# Toledo Firefighters Health Plan



714 Washington Street  
Toledo, Ohio 43624  
255-5314

## PART 1 MUST BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME		SOCIAL SECURITY NUMBER		NAME OF EMPLOYER	
HOME ADDRESS		EMPLOYEE BIRTH DATE MONTH DAY YEAR		OCCUPATION	
CITY & STATE		PHONE NO		IS PATIENT FULL TIME STUDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	
PATIENT (IF OTHER THAN EMPLOYEE) NAME		SEX	PATIENT RELATIONSHIP TO EMPLOYEE	PATIENT BIRTH DATE MONTH DAY YEAR	IS PATIENT MARRIED YES <input type="checkbox"/> NO <input type="checkbox"/>
DATE ACCIDENT OR SICKNESS BEGAN		IF INJURED, HOW AND WHERE DID ACCIDENT HAPPEN?			DID ACCIDENT HAPPEN AT WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>
NATURE OF INJURY DIAGNOSIS				PHYSICIAN'S NAME	
NAME OF SPOUSE		NAME AND ADDRESS OF SPOUSE'S EMPLOYER			
ARE YOU, THE PATIENT OR SPOUSE, COVERED UNDER ANY OTHER GROUP PLAN, HEALTH MAINTENANCE ORGANIZATION, GOVERNMENT PLAN, OR INSURANCE POLICY WHICH WILL ALSO PAY FOR ANY OF THE EXPENSES OF THIS CLAIM? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE NAME, ADDRESS & POLICY NUMBER OF PLAN PROVIDING BENEFITS NAME AND ADDRESS POLICY NO					

### IF PAYMENT IS TO BE MADE TO PROVIDER SIGN BELOW

**AUTHORIZATION TO PAY BENEFITS TO PROVIDERS**  
I hereby authorize payment of benefits directly to any providers of service, otherwise payable to me for services, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorization.

X \_\_\_\_\_ Date  
Covered Person

### PATIENT OR PARENT MUST SIGN BELOW

**AUTHORIZATION TO RELEASE INFORMATION**  
I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

X \_\_\_\_\_ Date  
Patient or Parent (if minor)

## PART 2 TO BE COMPLETED BY PHYSICIAN

13. Date symptom first appeared:		14. Date patient first consulted you for this condition:		15. Has patient ever had similar symptoms? <input type="checkbox"/> yes <input type="checkbox"/> no		16. Referring physician:	
17. Name and address of facility where service was rendered (other than home or office):				18. For services related to hospitalization Admission date: _____ Discharge date: _____			
19. Is patient totally disabled? <input type="checkbox"/> yes <input type="checkbox"/> no		Dates of total disability: From _____ To _____		20. Was outside lab work performed? <input type="checkbox"/> yes <input type="checkbox"/> no Charge: _____		21. Was service related to routine physical? <input type="checkbox"/> yes <input type="checkbox"/> no	
22. Diagnosis or nature of illness, injury or symptom. Relate diagnosis to procedure in column E by reference to numbers 1, 2, 3, etc. 1. _____ 2. _____ 3. _____							
23. A Date of service	B Place of service (see back)	C Type of service	D Description: Explain unusual services or circumstances related to procedures, medical services, or supplies furnished for each date given. <small>Procedure code Circle one: CPT IV or HCPCS</small>	E Diagnosis code ICD-9-CM	F Charges	G Days or Units	H (Internal use only)
24. Total charges						To make payment, your taxpayer identification number must be in Block 26.	
25. Patient account number			26. Identification number or (taxpayer ID)				
I certify that these services were performed by me or in my presence under my supervision.			27. Physician/provider name _____				
			Address _____ City _____ State _____ Zip _____ Signature _____				