Benefit Administrators, Inc.
Claims Divison
P.O. Box 211757
Eagan, MN 55121
1-800-298-7269

For FCE use only/Para uso exclusivo de FCE
Claim No./No. Reclamo

TYPE OR PRINT/A MAQUINA O EN MAYUSCULA

PATIENT & INSURED (SUBCRIBER) INFORMATION—PART A INFORMACION DEL PACIENTE Y ASEGURADO (SUSCRIPTOR)—PARTE A

1. Patient's Name (First, Middle Initial, Last)
Nombre del Paciente (Primer, Segunda Inicial, Apellido)

2. Patient's Date of Birth
Fecha de Nacimiento del Paciente

3. Employee Name (First, Middle Initial, Last)
Nombre del Empleado (Primer, Segunda Inicial, Apellido)

4. Patient's Address/Domicilio del Paciente
Address/Domicilio
City/Ciudad State/Estado Zip/Código Postal

5. Patient's Sex/Sexo del Paciente
Male/Masculino Female/Femenino

6. Employee I.D. or Medicare No.(include any letters)
No. de Identificación del Empleado o No. de Medicare (inclúyase cualquier letra)

7. Patient's Relationship to Insured
Relación entre el Paciente y el Empleado
Self Spouse Child Other
El Mismo Esposa Hijo Otro

8. Employee Group No. (or Group Name)
No. de Grupo del Empleado (o Nombre del Grupo)

9. DEPENDENT CLAIMS ONLY
RECLAMOS DE DEPENDIENTES SOLAMENTE

Dependent's Name Nombre del Dependiente	Relationship to you Relación con usted	Ever married? Yes_____ No_____ Casado alguna vez? Sí_____ No_____	Date of birth Fecha de nacimiento
Is child a full time student? Es el hijo un estudiante a tiempo completo?	Name and address of school Nombre y dirección del Colegio		Date last attended Ultima fecha de asistencia
Is child employed? Está el hijo empleado?	Name and address of Employer Nombre y dirección del Patrón		Date employed Fecha de inicio del empleo

10. Other Health Insurance Coverage — enter name of policyholder and plan name and address and policy or medical assistance number
Otras Coberturas de Seguros de Enfermedad — escriba el nombre del poseedor de la póliza y el nombre del plan y la dirección y el número de la póliza o de la asistencia médica

11. Was condition related to: A. Patient's employment? Yes _____ No ____
B. An auto accident? Yes _____ No ____
Se relaciona la situación con: A. Empleo del paciente ? Sí_____ No ____
B. Un accidente de automóvil? Sí_____ No ____

12.Employee Address/Domicilio del Empleado Home/Casa ☎
Address/Domicilio
City/Ciudad State/Estado Zip/Código Postal

13. Patient's authorized signature
I authorize the release of any medical information necessary to process this claim.
Firma autorizada del paciente
Yo autorizo la difusión de cualquier información médica necesaria para procesar este reclamo

14. I authorize payment of medical benefits to undersigned physician or supplier for service described below.
Yo autorizo el pago de beneficios médicos al médico o al proveedor abajo firmantes para el servicio descrito abajo.
Signed (Employee or authorized person)/Firmado (Empleado o persona asegurada o autorizada)

PHYSICIAN OR SUPPLIER INFORMATION—PART B INFORMACION DEL MEDICO O PROVEEDOR—PARTE B

15. Name of referring physician
Nombre del médico examinador

16. For services related to hospitalization give hospitalization dates.
Para aquellos servicios relacionados con una hospitalización, proporcione las fechas de hospitalizacíon.
Admitted/Entrada Discharged/Salida

17. Name & address of facility where services rendered (if other than home or office)
Nombre y dirección del centro que proporcionó los servicios (si no fué en el negocio o en la oficina)

18. Was laboratory work performed outside your office?
Se realizó trabajo de laboratorio fuera de la oficina?
Yes _____ No/Sí _____ No

19. Diagnosis or nature of illness or injury. Relate diagnosis to procedure in column D by reference to numbers 1, 2, 3, etc., or DX code.
Diagnóstico o naturaleza de la enfermedad o lesión. Relacione el diagnóstico con el procedimiento en la columna D mediante referencia a los números 1, 2, 3, etc., o mediante código DX
1.
2.
3.
4.

20. A Date of service Fecha del servicio	B Place of service Lugar del servicio	C Procedure code (identify)/Código del procedimiento (Identifique.)	Fully describe procedures, medical services or supplies furnished for each date given (Explain unusual services or circumstances) Describa completamente procedimientos, servicios médicos o suministros proporcionados para cada fecha dada. (Explique servicios o circunstancias excepcionales.)	D Diagnosis Code/Código del Diagnóstico	E Charges Cargo	F

21. Signature of Physician or Supplier
Firma del Médico o Proveedor

22. Accept assignment (government claims only)
Acepta Asignación (reclamos del gobierno solamente)
Yes/Sí No

23. Total Charge
Cargos Totales

24. Amount paid
Cantidad pagada

25. Balance due
Saldo a pagar

26. Your Social Security No.
Su No. del Seguro Social

30. Physician's or Supplier's Name, Address, Zip Code & Telephone No.
Nombre, dirección, código postal & No. Teléfono del Médico o Proveedor

28. Your Patient's Account No.
No. de Cuenta de Su Paciente

29. Your Employer I.D. No.
No. de identificación de su patrón

I.D. No./No. I.D.

INSTRUCTIONS FOR FILING A CLAIM

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Any person who **knowingly presents a false or fraudulent claim** for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. **COMPLETE EMPLOYEE INFORMATION SECTION • USE A SEPARATE CLAIM FORM FOR EACH MEMBER OF THE FAMILY.**
   - **IMPORTANT** - A completed claim form (FCE's or the provider's) must be included with each submission for each member of the family for each separate accident or illness.
   - **IMPORTANT** - Be certain your social security number appears on the claim form (Part A, Block 6).
   - **IMPORTANT** - If you wish your benefits paid directly to the physician or provider of service, sign the assignment of benefits block (Part A, Block 14).
   - **IMPORTANT** - You must sign and date your claim form (Part A, Block 13).This block must be signed by the patient. For minor children, it should be signed by the parent or legal guardian.
2. **ATTENDING PHYSICIAN OR PROVIDER INFORMATION SECTION SHOULD BE COMPLETED FOR...**
   - Surgery • Doctor's Visits • Hospital Stay • X-Ray/Lab Charges • Pharmacy

   Be sure to include procedure code and ICD-9 diagnosis code or printed descriptors of each (Part B, Blocks 19 and 20C).
3. **Or you may attach itemized bills from the provider. These must include:**

   Employee Name
   Patient Name
   Provider Name
   Type of Service
   Date of Service
   Diagnosis
   Charge for Service

   Pharmacy Bills must also include:
   Prescription Number
   Drug Name
   Charge for Drug

   Make copies of all bills submitted - bills will not be returned to you. Receipts and canceled checks are not acceptable.
4. **Mailing Instructions • Send your completed claim form and itemized bills to:**

   FCE Benefit Administrators, Inc.
   Claims Divison
   P.O. Box 211757
   Egan, MN 55121

   Telephone: 800-298-7269 for assistance.

   Failure to provide all required information may result in a delay in the processing of your claim.
5. **If you are using a PPO Provider they will submit the claim for you.**

INSTRUCCIONES POR ARCHIVO UN RECLAMO

Cualquiera persona que con conocimiento archiva una declaración de reclamo que contiene cualquiera falsedad o cualquiera información falsa, incompleta o engañosa, estaría culpable de un acto criminal castigado bajo la ley y estaría súbdito a penalidades cíviles.

1. **COMPLETE LA SECCION DE INFORMACION DEL EMPLEADO**
   USE UNA FORMA DE RECLAMO SEPARADA POR CADA MIEMBRO DE LA FAMILIA.
   - **IMPORTANTE**- Una forma de reclamo completó (FCE o el proveedor) tiene que estar incluido con cada sumisión por cada miembro de la familia, por cada accidente o enfermedad separado.
   - **IMPORTANTE**- Esté seguro que su número de seguro social aparezca en la forma de reclamo (Parte A, Bloque 6).
   - **IMPORTANTE**- Si usted quiere que sus beneficios sean pagado directamente al médico o proveedor de servicio, firme el bloque de asignación de los beneficios (Parte A, Bloque 14).
   - **IMPORTANTE**- Tiene que firmar y fechar su forma de reclamo (Parte A, Bloque 13). Esté bloque tiene que ser firmado por el paciente. Por niños ménores, debe ser firmado por el padre o el tutor.
2. **LA SECCION DE INFORMACION POR EL MÉDICO ATENDIENDO O EL PROVEEDOR DEBE SER COMPLETADO PARA.**
   - Cirugía • Visitas de médico • Permanecía de hospital • Radiografía / Cargos del laboratorio • Farmacia

   Esté seguro de incluir codificación del procedimiento e ICD-9 codificación del diagnosis o imprimió descripciónes de ambos (Parte B, Bloques 19 y 20C).
3. **O puede incluir facturas de detalló del proveedor. Estos deben incluir:**

   Nombre del empleado
   Nombre de paciente
   Nombre del proveedor
   Tipo de Servicio
   Fecha de Servicio
   Diagnosis
   Cargo por Servicio

   Facturas de la farmacia también deben incluir:
   N mero de la prescripciÛn
   Nombre de la droga
   Cargo por Droga

   Haga copias de todas facturas sometidó- no se le volveran facturas. Recibos y cheques cancelados no son aceptable.
4. **Instrucciones para mandar por correo • Mande su forma completa de reclamo y facturas de detallóa:**

   FCE Benefit Administrators, Inc.
   Claims Divison
   P.O. Box 211757
   Egan, MN 55121

   Teléfono: 800-298-7269 por ayuda.

   Falta de suministar todo la información necesitada podra resultar en tardanza en el proceso de su reclamo.
5. **Si usted usa un proveedor de PPO, someterá la reclama por usted.**

Important Notice

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.

- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

- ***For residents of Maine, Tennessee and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

- ***For residents of Ohio:*** 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.

- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

- ***For residents of Texas:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.