INSURANCE BENEFITS PROVIDED BY
GULF GUARANTY EMPLOYEE BENEFITS SERVICES, INC

A Gulf Guaranty Life Insurance Company
7 River Bend Place Flowood, MS. 39232
Telephone: 1-877-572-4953 Fax: 601-981-6805
Email: claims@gulfguaranty.com

HOSPITAL ADMISSION CLAIM FORM

Enrolled Member's Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) ___ / ___ / ___

Telephone Number where we can reach you ___ - ___ - ___

*Home Address

*City | *State | *Zip Code ___ - ___

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy) ___ / ___ / ___

*Sex: ☐ Male ☐ Female

*Relationship: ☐ Primary Policyholder ☐ Spouse ☐ Dependent Child

Is treatment due to an injury? ☐ No ☐ Yes ***If yes, please complete the following questions related to the injury:***

- Date of the injury: ______/______/______
- Describe how the injury occurred: ______________________________
- Was this disability caused by an incident that occurred while performing the duties of the patient's employment? ☐ No ☐ Yes
- Was this a motor vehicle accident in which the patient was the driver? ☐ No ☐ Yes (If yes, please submit a copy of the Police Report.)

Is treatment due to a sickness? ☐ No ☐ Yes ***If yes, please complete the following questions related to the sickness:***

- Symptoms first occurred on: ______/______/______
- First date of treatment for this condition: ______/______/______
- If diagnosed with cancer, date of initial diagnosis: ______/______/______
- Was the patient treated by any other physicians for this sickness or a related condition? ☐ No ☐ Yes

  If yes, physician's name(s): ______________________________

  Phone Number(s): ______________________________

  Address: ______________________________

Policyholder Information:

*Last Name | Suffix | *First Name | MI

*Date of Birth (mm/dd/yy) ___ ___ / ___ ___ / ___ ___

Patient Information:

*Last Name | *First Name | *Date of Birth (mm/dd/yy) ___ ___ / ___ ___ / ___ ___

Pregnancy claims:

- Date of delivery: ____/____/____ ☐ Vaginal ☐ Cesarean
- If not delivered, expected delivery date: ____/____/____
- Please advise of any complications: ______________________________

For all claims, please complete all remaining sections.

- Please provide the name, address and phone number of the patient's primary treating physician.
  Name: ______________________________ Phone Number: ______________________________
  Address: ______________________________
- Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized hospital bill, UB04, or HCFA 1500)
  Hospital Name: ______________________________
  City: ______________________________ State: ______________________________
- Was the patient confined to the intensive care unit as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)
- Was the patient confined to a rehabilitation unit as a result of this condition? ☐ No ☐ Yes (If yes, please submit the itemized bill, UB04, or HCFA 1500.)
- Was patient treated in an emergency room as a result of this condition? ☐ No ☐ Yes (If yes, please submit the emergency room report, UB04, or HCFA 1500.)
  Hospital name: ______________________________ Date of treatment: ____/____/____
- Was the patient transported by an ambulance as a result of this condition? ☐ No ☐ Yes (If yes, please submit the ambulance bill)
- Was surgery performed as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the operative report, UB04, or HCFA 1500.)
- Were medical imaging services (i.e. CT Scan, MRI, EEG, etc.) provided as a result of this condition? ☐ No ☐ Yes (If yes, please submit a copy of the exam report and/or billing, UB04, or HCFA 1500.)

Please provide primary plan EOB when filing a claim

______________________________ ______________________________ ______________________________

POLICYHOLDER/PATIENT SIGNATURE **FAMILY RELATIONSHIP, IF NOT POLICYHOLDER** **DATE**