Deductible Guard

by Gulf Guaranty

pay less out of pocket for healthcare

HOSPITAL ADMISSION CLAIM FORM

Policyholder 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.)

_____ _____ _____

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

SUBMIT CLAIMS TO : GULF GUARANTY DEDUCTIBLE GUARD
ATTN: Claims Department • P.O. BOX 14977 • JACKSON, MS 39236
For information or to check claim status, call 601-981-9505 or email claims@gulfguaranty.com
Claims may be faxed to 601-981-6805