

USA VOLLEYBALL MEDICAL CLAIM FORM 2003 SEASON

TO BE COMPLETED BY PHYSICIAN OR PROVIDER

PATIENT NAME: _____ DATE: _____

DIAGNOSIS AND CONCURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME)

REPORT OF SERVICES (OR ATTACH ITEMIZED BILL)

<u>DATE OF SERVICE</u>	<u>PLACE OF SERVICE</u>	<u>DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED</u>	<u>PROCEDURE CODE - IF USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)</u>	<u>CHARGES</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

O - Doctor's Office IH - Inpatient Hospital NH - Nursing Home
H - Patient's Home OH - Outpatient Hospital OL - Other Locations

TOTAL CHARGES \$ _____
AMOUNT PAID \$ _____
BALANCE DUE \$ _____

* ICDA - International Classification of Diseases
** CPT - Current Procedural Terminology (current edition)

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
--	--

NAME AND ADDRESS OF REFERRING PHYSICIAN

TO THE BEST OF YOUR KNOWLEDGE, INFORMATION AND BELIEF, HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES NO IF YES, WHEN AND DESCRIBE

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
-------------	---------------------------------	------------------	---------------	------------------

ADDRESS	CITY OR TOWN	STATE	ZIP CODE	SOCIAL SECURITY OR TAX IDENTIFICATION
----------------	---------------------	--------------	-----------------	--

RETURN THIS FORM TO:

Summit America Insurance Services
Attn: Angela King
5001 College Blvd., Suite 216
Leawood, Kansas 66211

**FOR FURTHER INFORMATION OR QUESTIONS, PLEASE CALL SUMMIT - CLAIMS DEPARTMENT AT 800-955-1991
OR SEND A FAX TO 913-327-0201.**