

**Complete all items and attach original itemized bills.**

Employer				Group Number			
Employee Last Name Only		First Name		Middle Initial	Employee's Date of Birth	Social Security Number	
Employee Home Address:	Number	Street	City	State	Zip	Home Telephone ( )	
First and Last Name of Spouse		Spouse's Date of Birth	Social Security Number		Is spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Name, Address and Telephone # of Employer:		
First and Last Name of Patient		Patient's Date of Birth	Relationship to Employee <input type="checkbox"/> Husband <input type="checkbox"/> Natural Child <input type="checkbox"/> Wife <input type="checkbox"/> Other:				
If patient is a child, is he or she employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Name and Address of Employer:		If patient is a child over age 18, is he or she attending a college or university? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please indicate name and address of college or university:			For how many credit hours is student enrolled?		
Is the patient covered under any other <b>Group</b> Insurance, a Health Maintenance Organization (HMO), "No-Fault" Auto Insurance or Government Plan which would also provide benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				Insurance Carrier: _____		Policy # _____	
Address:							
Is claim a result of <input type="checkbox"/> Illness <input type="checkbox"/> Accident	Give diagnosis or describe the illness or injury:					Date accident happened or illness began:	
Was patient's injury or illness caused by his/her work? <input type="checkbox"/> Yes <input type="checkbox"/> No		If an accident, where and how did it happen?					
<b>AUTHORIZATION TO RELEASE INFORMATION</b> I hereby authorize the provider of service to release any information acquired in the course of my examination or treatment (patient or parent-guardian if minor).				All benefit payments will automatically be assigned to the provider of service unless you have paid the bill. Have you paid the attached bills? <input type="checkbox"/> Yes <input type="checkbox"/> No			
X _____ DATE _____				X _____ DATE _____			

**PROCEDURE FOR FILING A CLAIM**

1. All claims should be filed within 90 days of the date of service.
2. Complete **ALL** questions on form.
3. Only submit **ITEMIZED** bills; (we can not accept photocopies, balance due statements, or cash register receipts)

Itemized statements must be signed by the provider of service and show:

- a) Patient's name
- b) Diagnosis
- c) Date of Service
- d) Description of each service rendered
- e) Amount charged for each service

4. Attach **ORIGINAL** bills to this claim form and mail to:

**ADMINISTRATIVE ENTERPRISES, INC.**  
**5810 WEST BEVERLY LANE**  
**GLENDALE, AZ 85306-1800**  
**(602) 789-1170 (800) 762-2234**

5. A copy of this completed claim form can be used when submitting additional bills for the same injury or illness.
6. Benefit payments are automatically assigned to your doctor or hospital. If you have made payment, be sure the bill is clearly marked as paid when submitted to AEI for processing.

**FAILURE TO COMPLY WITH THIS PROCEDURE MAY RESULT IN DELAYED PAYMENT OF YOUR CLAIM**