



Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

5011 GATE PARKWAY, BLDG. 200 • JACKSONVILLE, FLORIDA 32256

ATTN: Group Claims Department

To receive claims assistance, please call 1-800-696-8562

HOSPITAL INDEMNITY CLAIM STATEMENT

INSTRUCTIONS FOR THE ATTENDING PHYSICIAN:

1. Print or type complete answers to the "Attending Physician's Statement" section. Attach extra paper, if needed, and sign and date it.
2. Attach an itemized bill for all covered services to date.

Attending Physician's Statement

ATTENDING PHYSICIAN'S STATEMENT (Please Print)

1. Diagnosis and concurrent conditions (include ICD Code(s))			
2. Date symptoms first appeared (Mo/Day/Yr):		3. Date patient first consulted you (Mo/Day/Yr):	
4. Date admitted to hospital (Mo/Day/Yr): _____ Date discharged from hospital (Mo/Day/Yr): _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Hospital Name: _____ Address, City, State, Zip: _____			
5. Have you treated this patient for other conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give dates and describe: _____ _____ _____ Has patient ever had same or similar condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, Date: _____			
6. Was patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name and address of referring doctor: _____ _____			
FRAUD NOTICE: 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.			
7. Name of Attending Physician (Please print):			8. Degree:
9. Address:		City:	State:
		Zip code:	
10. Telephone numbers: Office #:			Fax #:
11. Attending Physician's Signature:			Date (Mo/Day/Yr):