

**PINNACLE CLAIMS MANAGEMENT, INC.
MEDICAL CLAIM BENEFIT FORM**

DO NOT USE THIS FORM TO REPORT WORK RELATED INJURIES

NOTICE: FAILURE TO COMPLETE ALL APPLICABLE SECTIONS ON THIS SIDE OF THE CLAIM FORM MAY RESULT IN A DELAY OF CLAIM PROCESSING.



MAIL TO: 17620 FITCH STREET
IRVINE, CA 92614
(949) 863-1000

SECTION A – TO BE FULLY COMPLETED BY THE EMPLOYEE

Employee's Name		Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth / /	Employee's Social Security #	
Home Address		City	State	Zip Code	
Employer/Association		Location	Are you an Owner or Partner? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Occupation – Description of Duties			Are You Actively Employed or Retired?		
If divorced and claim is for child, please provide other parent's:		Is Employee Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>			
Name	Address	Employer Name/Location	Phone		

SECTION B – DEPENDENT CLAIM (COMPLETE ONLY IF CLAIM IS FOR A DEPENDENT)

Claim is for: Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		Relationship	Dependent's Name	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth
Dependent's Social Security #	Is Dependent: Retired <input type="checkbox"/> Working <input type="checkbox"/>	If working Full-time <input type="checkbox"/> Part-time <input type="checkbox"/>	Employer Name		
Permanent Home Address					
Member of an Association? Yes <input type="checkbox"/> No <input type="checkbox"/>	Married Yes <input type="checkbox"/> No <input type="checkbox"/>	19 years or older? Yes <input type="checkbox"/> No <input type="checkbox"/>	A Full-time Student? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of School		

SECTION C – ACCIDENT INFORMATION

Does this claim involve an accident? Yes No If yes:

- Did the accident occur while you were on the job? Yes No
- What date were you injured? _____ What time? _____ a.m. p.m.
- What happened? _____

SECTION D – OTHER MEDICAL COVERAGE

Are you or any member of your family covered by any other Plan which provides medical benefits? Yes No If yes:

- Who? Name _____ Social Security # _____
- A Western Growers Plan? Plan Name _____
- Another Insurance Company? Name _____ Policy # _____

Address _____

SECTION E – RELEASE OF INFORMATION

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize any doctor, hospital, pharmacy, medical supplier, other insurance company, employer, or any organization to release any information regarding the medical history, treatment, disability or benefits payable for this claim, to Pinnacle Claims Management, Inc. or any individual designated as its agent, for the purpose of validating and determining benefits payable in connection with this claim. Data without personal identification may be extracted for use in statistical studies. The authorization or photostatic copy of the original shall be valid for one year from the date of signature.

Parent or Guardian Signature

Employee's (or Spouse's) Signature

Date

SECTION F – ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS:
I hereby authorize Pinnacle Claims Management, Inc. to make payment directly to the provider of services any benefits due me for those services.
NOTE: Authorization to pay the provider is not valid for services outside the United States.

Employee's (or Spouse's) Signature

Date

