THIS CLAIM REPORT IS USED FOR ANY TYPE OF HEALTH CLAIM AND MUST BE RETURNED TO
PROFESSIONAL INSURANCE COMPANY, P.O. BOX 85656, LINCOLN, NE 68501-5656 PHONE 800-289-1122

PART A TO BE COMPLETED BY PATIENT (INSURED)

PATIENT'S NAME AND ADDRESS

INSURED'S NAME AND ADDRESS IF PATIENT IS A DEPENDENT

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNED (PATIENT, OR PARENT IF MINOR)

DATE

PART B ATTENDING PHYSICIAN'S STATEMENT

For routine FIRST-AID claims, this side is not usually required, if a copy of the bill showing Patient's name, diagnosis, charges, and date incurred is furnished along with Claimant's Statement on reverse side.

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

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES NO

3. IF CONDITION IS DUE TO ACCIDENT, PLEASE GIVE DETAILS OF ACCIDENT.

4. IS CONDITION DUE TO PREGNANCY? YES NO IF YES, EXPECTED DATE OF DELIVERY DATE OF LMP

5. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL). IF A PREVIOUS FORM HAS BEEN SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT.

Date of Services (Mo. Day, Yr.)	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code – If used (If code other than CPT used, give name)