



Application For Benefits

Place of Employment	Group Numbers
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MAIL TO:
Aultra Administrative Group
P.O. Box 6910
Canton, OH 44706-0910
Phone: 330-363-2050 OR 855-270-8497 Fax: 330-363-7717

EMPLOYEE STATEMENT

Each family member must complete one form annually at each physician office. ACTIVE RETIRED SALARIED HOURLY

PATIENT & EMPLOYEE INFORMATION

1. PATIENT'S NAME (First Name, Middle Initial, Last Name)		2. PATIENT'S DATE OF BIRTH		3. EMPLOYEE NAME (First Name, Middle Name, Last Name)	
4. PATIENT'S ADDRESS (Street, City, State, ZIP code)		5. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		6. EMPLOYEE ADDRESS (Street, City, State, ZIP code)	
PHONE #		7. PATIENT'S RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		8. MARITAL STATUS: SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	
9. ARE YOU OR ANY OF YOUR DEPENDENTS EMPLOYED ELSEWHERE? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes where _____ Phone _____		10. EMPLOYEE I.D. NO. (Soc. Sec. No.)		12. WAS CONDITION RELATED TO A. Patient's employment <input type="checkbox"/> yes <input type="checkbox"/> no B. An Auto accident <input type="checkbox"/> yes <input type="checkbox"/> no Date/Description/Location of Accident _____	
11. OTHER GROUP HEALTH COVERAGE - Enter name of Policyholder and Plan Name and Address and Policy Number		13. IS PATIENT A FULLTIME STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes where? School: _____ Expected Date of Graduation _____ City: _____		14. IF ELIGIBLE, IS PERSON ENROLLED IN: Federal Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Federal Medicare Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date of Part A is _____ If Yes, Effective Date of Part B is _____	
15. ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY INSURANCE COMPANY, ORGANIZATION, EMPLOYER, HOSPITAL, PHYSICIAN, OR PHARMACIST TO RELEASE ANY INFORMATION REQUESTED WITH REGARD TO THIS CLAIM AND THE EXPENSES REPORTED. _____ Signed (Patient or Authorized Person) _____ Date _____		16. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. _____ Signed (Employee or Authorized Person) _____			

PHYSICIAN OR SUPPLIER INFORMATION (If Patient Completes, Must Attach Itemized Receipts)

17. DATE OF ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		18. DATE FIRST CONSULTED YOU FOR THIS CONDITION		19. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. DATE PATIENT ABLE TO RETURN TO WORK		21. DATES OF TOTAL DISABILITY From _____ Through _____		DATES OF PARTIAL DISABILITY From _____ Through _____	
22. NAME OF REFERRING PHYSICIAN		23. FOR SERVICES RELATED TO HOSPITALIZATION GIVE DATES Admitted _____ Discharged _____		25. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> Yes <input type="checkbox"/> No Charges _____	
24. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If Other Than Home or Office)		26. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE			

27. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D DIAGNOSIS CODE	E CHARGES	F
		PROCEDURE CODE	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)			

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements attached apply to this bill and are made a part hereof)		29. ACCEPT ASSIGNMENT <input type="checkbox"/> Yes <input type="checkbox"/> No		30. TOTAL CHARGE		31. AMOUNT PAID		32. BALANCE DUE	
SIGNED _____ DATE _____		33. YOUR SOCIAL SECURITY NUMBER		34. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.					
35. YOUR PATIENT'S ACCOUNT NUMBER		36. YOUR EMPLOYER I.D. NO.		I.D. NO.					

PLACE OF SERVICE CODES
 (IH) - INPATIENT HOSPITAL 4-(H) - PATIENT'S HOME 7-(NH) - NURSING HOME O-(OL) - OTHER LOCATIONS
 (OH) - OUTPATIENT HOSPITAL 5 - DAY CARE FACILITY (PSY) 8-(SNF) - SKILLED NURSING FACILITY A-(IL) - INDEPENDENT LABORATORY
 (O) - DOCTORS OFFICE 6 - NIGHT CARE FACILITY (PSY) 9 - AMBULANCE B - OTHER MEDICAL/SURGICAL FACILITY

AultCare/Aultra General Tag Lines for the State of Ohio

English

If you, or someone you are helping, have questions about **AultCare/Aultra** you have the right to get help and information in your language at no cost. To speak with an interpreter, call **Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 330.363.2393 Outside Stark County: 1.866.633.4752**

Spanish

Español

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca **AultCare/Aultra** tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al **Local : 330.363.6360 Fuera del condado de Stark : 1.800.344.8858 TTY Local : 330.363.2393 Fuera del condado de Stark : 1.866.633.4752**

Chinese

中文

如果您，或是您正在協助的對象，有關於 **AultCare/Aultra 保險公司** 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 本地：330.363.6360 斯塔克縣外：1.800.344.8858 TTY 線 本地：330.363.2393 斯塔克縣外：1.866.633.4752。

German

Deutsche

Falls Sie oder jemand, dem Sie helfen, Fragen zum **AultCare/Aultra** haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752 an.**

Arabic

العربية

العربية، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب **AultCare/Aultra** إن كان لديك أو لدى شخص تساعد أسئلة بخصوص شركة التأمين خارج مقاطعة ستارك . 1.866.633.4752 المحلي: الخط 330.363.2393 خارج مقاطعة ستارك : 1.800.344.8858

Pennsylvania Dutch

Deitsch

Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut **AultCare/Aultra** hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du **Local: 330.363.6360 Außerhalb von Stark County: 1.800.344.8858 TTY –Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752** uffrufe.

Russian

русский

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу **Страховая компания AultCare/Aultra**, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 330.363.2393 Вне Старка County : 1.866.633.4752.**

French

Français

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de **Compagnie d'Assurance AultCare/Aultra**, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, **Appelez Locale 330.363.6360 En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 330.363.2393 En dehors du comté de Stark : 1.866.633.4752.**

Vietnamese

Việt Nam

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về **Công ty Bảo hiểm AultCare/Aultra** quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi **Địa phương: 330.363.6360 Bên ngoài của Stark County : 1.800.344.8858 TTY đường dây Địa phương: 330.363.2393 Bên ngoài của Stark County : 1.866.633.4752.**

Cushite-Oromo

Isin yookan namni biraa isin deeggartan **AultCare/Aultra**, irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 330.363.2393 Outside of Stark County: 1.866.633.4752** tiin bilbilaa.

Korean

한국어

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 **AultCare/Aultra 보험 회사**에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 **지역 : 330.363.6360 스타크 카운티 의 외부 : 1.800.344.8858 TTY 라인 지역 : 330.363.2393 스타크 카운티 의 외부 : 1.866.633.4752** 로 전화하십시오.

Italian

Italiano

Se tu o qualcuno che stai aiutando avete domande su **AultCare/Aultra**, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare **Locale: 330.363.6360 Al di fuori di Stark County : 1.800.344.8858 TTY linea Locale: 330.363.2393 Al di fuori di Stark County : 1.866.633.4752.**

Japanese

日本語

ご本人様、またはお客様の身の回りの方でも **AultCare/Aultra 保険会社**についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、**ローカル : 330.363.6360 スターク郡の外 : 1.800.344.8858 TTY ライン ローカル : 330.363.2393 スターク郡の外 : 1.866.633.4752** までお電話ください。

Dutch

Nederlands

Als u, of iemand die u helpt, vragen heeft over **AultCare/Aultra**, heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten. Om te praten met een tolk, bel **Local : 330.363.6360 Buiten Stark County : 1.800.344.8858 TTY Line Local : 330.363.2393 Buiten Stark County : 1.866.633.4752.**

Ukrainian

український

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про **Страхова компанія AultCare/Aultra**, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на **Місцевий : 330.363.6360 Поза Старка County : 1.800.344.8858 TTY лінія Місцевий : 330.363.2393 Поза Старка County : 1.866.633.4752.**

Romanian

Română

Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind **Compania de Asigurari AultCare/Aultra**, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la **Locale : 330.363.6360 In afara Stark Judet : 1.800.344.8858 TTY linie Locale : 330.363.2393 In afara Stark Judet : 1.866.633.4752.**

Non-Discrimination Notice:

AultCare/Aultra complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AultCare/Aultra does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. AultCare/Aultra provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). AultCare/Aultra provides free language services to people whose primary language is not English, such as: Qualified interpreters and information written in other languages.

If you need these services, or if you believe that AultCare/Aultra has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: AultCare/Aultra Civil Rights Coordinator, 2600 6th St. S.W. Canton, OH 44710, 330-363-7456, CivilRightsCoordinator@aultcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.