Contact Information & Claims Submission:
800-283-2524 or 856-470-1200
856-888-2836 (Fax)
claims@iaatpa.com
IAA - PO Box 5082
Mt. Laurel, NJ 08054
www.iaatpa.com

Medical/Rx Claim Submission Form

Employee Section

Employer:		**Group Number:**	
Employee Name:		Member ID Number:	
Employee Address:			
City:		State:	Zip:
Are you currently working? ☐ Yes ☐ No	If No, Why? ☐ Lay Off ☐ FMLA ☐ Disability ☐ Other, please explain _____		
If, "no" provide the last day you worked. _____/_____/_____	_____		

COMPLETE THIS SECTION IF THE CLAIM IS NOT FOR THE EMPLOYEE

Patients Name:		Date of Birth:
Relationship:	Is Patient Employed? ☐ Yes ☐ No	Does The Patient Have Other Insurance? ☐ Yes ☐ No
Name & Address of Patients Employer _____ _____ _____	Patients Other Insurance Information Carrier Name _____ Address _____ _____ Policy Number _____	

COMPLETE THIS SECTION IF THE CLAIM IS FOR AN ACCIDENT OR WORK RELATED INJURY

Was the accident work related ☐ Yes ☐ No	Is this claim from an accident? ☐ Yes ☐ No *(If "yes" complete the entire section)*	
When did the accident occur?		
How did the accident occur?		
Where did the accident occur?		
Has a lawyer been retained? ☐ Yes ☐ No *(If "yes" provide attorneys information)*	Law Firm:	Attorneys Name:
Address:		Phone Number:

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any Insurance Company, Organization, Employer, Physician or Hospital to release information regarding my current illness.

Patient's Signature:_____ Date:_____

IAA - PO Box 5082
Mt. Laurel, NJ 08054

Medical/Rx Claim Form
Optional Form – attached receipt if not completed.

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME: (First, M.I., Last)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First, M.I., Last)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)	5. PATIENT'S SEX M ☐ F ☐ 7. RELATIONSHIP TO INSURED SELF SP CH OTHER ☐ ☐ ☐ ☐	6. INSURED'S ID, MEDICARE, AND/OR MEDICAID# 8. INSURED'S GROUP # OR NAME
9. OTHER HEALTH INSURANCE COVERAGE – Enter Name of Policyholder, Plan Name, Address and Policy or Medical Assistance Number	10. WAS CONDITION RELEATED TO A. PATIENT'S EMPLOYMENT YES ☐ ☐ NO B. AN ACCIDENT YES ☐ ☐ NO	11. INSURED'S ADDRESS (Street,City,State,Zip Code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical information necessary to process the claim and request payment of benefits Signed Dated		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW Signed (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF:	ILLNESS (FIRST SYMPTOM OR INJURY ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMLAR SYMPTOMS YES ☐ NO ☐	16A. IF AN EMERGENCY CHECK HERE
17. DATE PATIENT WAS ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH	
19. NAME OF REFERRING PHYICIAN OR OTHER SOURCE (e.g. public health agency)			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES ☐ NO ☐ CHARGES	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATED DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFFERENCE NUMBERS 1,2,3, ETC OR DX CODE A. 1. 2. 3. 4.			B. EPSDT YES ☐ NO ☐ FAMILY PLANNING YES ☐ NO ☐ PRIOR AUTHORIZATION	

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE	(Explain Unusual Services or Circumstances)	D. DX CODE	E. CHARGES		F. DAYS/ UNITS	G. T.O.S.	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	26. ACCEPT ASSIGNMENT YES ☐ NO ☐ 30. YOUR SOCIAL SECURITY NUMBER	27. TOTAL CHARGE	28. AMOUNT PAID / 29. BALANCE Due 31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
32. YOUR PATIENT'S ACCOUNT NUMBER	33. YOUR EMPLOYER ID NUMBER		ID NUMBER