PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

P.O. Box 4884 Houston, Texas 77210 (888)748-3040

DIRECT PRIMARY CARE Claim Form

A. POLICYHOLDER INFORMATION	B. PROVIDER OF SERVICE INFORMATION
Policy#:_____	**Name:**_____
Policyholder:_____	**Address:**_____
Patient:_____	**City, State, Zip:**_____
	Telephone #:_____

C1. SERVICES RENDERED	C2. SERVICES RENDERED	C3. SERVICES RENDERED
Service Date:_____	**Service Date:**_____	**Service Date:**_____
Diagnosis Code(s)_____	**Diagnosis Code(s)**_____	**Diagnosis Code(s)**_____
Office Visit CPT Code:_____	**Office Visit CPT Code:**_____	**Office Visit CPT Code:**_____
Radiology CPT Code(s):_____	**Radiology CPT Code(s):**_____	**Radiology CPT Code(s):**_____
Laboratory CPT Code(s):_____	**Laboratory CPT Code(s):**_____	**Laboratory CPT Code(s):**_____
Injection CPT Code(s):_____	**Injection CPT Code(s):**_____	**Injection CPT Code(s):**_____

D. PHYSICIAN SIGNATURE

I certify that the services above have been rendered to above named patient.

Physician Signature:_____**Date**_____

Please note that the above rendered services will be reimbursed in accordance with the Hospital Indemnity plan subject to all provisions, limitations, and exclusions of the policy.	**Benefits will not be assigned to the provider of service. Any reimbursement will be paid to the member of the policy.**

IMPORTANT- This claim submission must include a copy of your paid receipt received from your physician.