

MEMBER SUBMITTED HEALTH INSURANCE CLAIM FORM

FILING INSTRUCTIONS

- 1. Complete all items below including your signature and date. All of the information is essential for prompt and accurate processing of your claim(s). Please do not highlight information or use red ink. For optimum accracy please print in capital letters. Shade circles like this ● Not like this ⊗/⊙.
2. Submit the claim and attach an itemized statement of services from the healthcare provider to the address provided on the back your ID card.
3. Attached itemized bill must include:
• Provider's name and address (on the provider's stationary)
• Patient's full name (no nicknames, please)
• Date of each service/supply/purchase; Type of services /supply/purchase; Charge
• If prescription drugs prescription drug name and number
• For private duty nursing, Nurse's license number and shift worked
• For ambulance services, From – To and total mileage

NOTE: Cancelled checks, cash register receipts or personal itemizations are not acceptable as itemized bills
4. You must use a separate claim form for each patient. All expenses for one patient can be submitted with one claim form.

NOTE: YOU SHOULD MAKE A COPY OF YOUR COMPLETED CLAIM FORM AND ITEMIZED BILLS FOR YOUR RECORDS.

POLICYHOLDER INFORMATION

NAME ON ID CARD (first name, middle initial, last name)

Grid for Name on ID Card

IDENTIFICATION NUMBER ON ID CARD (including any letters)

Grid for Identification Number on ID Card

GROUP NUMBER ON ID CARD

Grid for Group Number on ID Card

STREET ADDRESS OF PERSON LISTED ON ID CARD

Grid for Street Address of Person Listed on ID Card

Grid for City, State, and ZIP Code

PATIENT INFORMATION

PATIENT'S NAME (first name, middle initial, last name)

Grid for Patient's Name

PATIENT'S STREET ADDRESS

Grid for Patient's Street Address

Grid for Patient's City, State, and ZIP Code

PATIENT'S DATE OF BIRTH

Grid for Patient's Date of Birth (MM/DD/YYYY)

PATIENT'S SEX

Radio buttons for MALE and FEMALE

PATIENT'S RELATIONSHIP TO THE PERSON NAMED ON ID CARD

Radio buttons for SELF, SPOUSE, CHILD, and OTHER



53505

OTHER INSURANCE COVERAGE INFORMATION

(If You Have An Explanation of Benefits, Please Attach). If patient is covered by another insurance plan, please complete the following:

INSURED'S NAME ON OTHER INSURANCE ID CARD	OTHER INSURANCE COMPANY'S NAME		
OTHER INSURANCE COMPANY POLICY NUMBER	STREET		
	CITY	STATE	ZIP CODE
IF SERVICE WAS A RESULT OF ACCIDENT, SHADE CIRCLE BELOW: <input type="radio"/> AUTOMOBILE ACCIDENT <input type="radio"/> WORK-RELATED ACCIDENT <input type="radio"/> OTHER: _____	DATE OF ACCIDENT		
	<input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY DISABILITY DATES THRU _____ _____		

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

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ASSIGNMENT OF BENEFITS: (Outside of Pennsylvania only)

ATTENTION EMPLOYEE:

This section applies to outside of Pennsylvania providers only. If you do not wish to sign, payment will be sent directly to you.

PLEASE NOTE: A separate claim form is needed for each provider to whom you are assigning benefits.

I hereby authorize payment to the provider of surgical and /or medical benefits, if any.

Employee Signature: _____ Date: _____

NOTE: PLEASE BE SURE THAT THE OUTSIDE PENNSYLVANIA PROVIDER'S TAX CERTIFICATION NUMBER IS PRINTED ON THE ITEMIZED BILL. IF TAX I.D. NUMBER IS NOT PROVIDED, PAYMENT WILL BE SENT TO THE EMPLOYEE/RETIREE.

CERTIFICATION:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, the Plan may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. The signer hereby authorizes any insurer, employer, organization or health care service provider to release to the plan all information relating to past, present and future health care examinations or treatments received by each person covered by this claim/application. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient name.

Signature: _____ Date: _____

REMEMBER TO ATTACH AN ITEMIZED STATEMENT OF SERVICES PERFORMED

53505

