

MEMBER CLAIM FORM

Do not file for prescription drugs on this form.

TIPS FOR FILING:

- Claims must be filed within 18 months from the date services were received or they will be denied for late filing.
- Complete a separate claim form for each covered family member.
- Type or print legibly.
- Enclose receipts and make copies for your records.
- **Do not file prescription drugs on this form. See the back of the form for filing information.**
- Do not file a claim if the Provider or Hospital is filing for the same services.
- Attach Explanation of Benefits if these services are covered by another group health policy.
- Mailing instructions are included on the back of this form.

SECTION I: PATIENT INFORMATION

SUBSCRIBER NUMBER											
BEGIN WITH 3 ALPHA PREFIX			2 DIGITS PRECEDING PATIENT'S NAME <i>(Please see ID Card)</i>								
PATIENT LAST NAME						FIRST NAME			MI		
PATIENT DATE OF BIRTH						PATIENT SEX					
						<input type="checkbox"/> MALE			<input type="checkbox"/> FEMALE		
PATIENT RELATIONSHIP TO SUBSCRIBER											
<input type="checkbox"/> SELF		<input type="checkbox"/> CHILD		<input type="checkbox"/> SPOUSE		<input type="checkbox"/> OTHER _____					

SECTION II: SUBSCRIBER INFORMATION

SUBSCRIBER NAME		
ADDRESS (LINE 1)		
ADDRESS (LINE 2)		
CITY	STATE	ZIP CODE
<input type="checkbox"/> PLEASE CHECK HERE IF ADDRESS HAS CHANGED		

SECTION III: OTHER INSURANCE INFORMATION

PLEASE COMPLETE THE INFORMATION BELOW IF THE PATIENT IS COVERED BY ANOTHER GROUP HEALTH INSURANCE.

Does the patient have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OTHER HEALTH INSURANCE COMPANY NAME	OTHER POLICY NUMBER
OTHER POLICY HOLDER'S NAME	OTHER POLICY HOLDER'S EMPLOYER NAME

PLEASE COMPLETE THE INFORMATION BELOW IF THE PATIENT IS COVERED BY MEDICARE:

MEDICARE HEALTH INSURANCE CLAIM NUMBER	IS PATIENT ELIGIBLE FOR:
	<input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART A AND B

PLEASE NOTE: IF YOUR OTHER INSURANCE OR MEDICARE POLICY IS PRIMARY, PLEASE ATTACH A COPY OF THE EXPLANATION OF BENEFITS. YOUR CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

I certify that the information on this form is correct and the expenses incurred were necessary for the services filed.

SUBSCRIBER SIGNATURE _____ DATE _____ TELEPHONE NUMBER WE CAN CONTACT YOU (IF NECESSARY) _____

Please use the reverse side of this form to provide a description of services you are filing for.

