53505

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 accuracy 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)

IDENTIFICATION NUMBER ON ID CARD (including any letters)

GROUP NUMBER ON ID CARD

STREET ADDRESS OF PERSON LISTED ON ID CARD

CITY | STATE | ZIP CODE

PATIENT INFORMATION

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

PATIENT'S STREET ADDRESS

CITY | STATE | ZIP CODE

PATIENT'S DATE OF BIRTH

MM / DD / YYYY

PATIENT'S SEX

○ MALE ○ FEMALE

PATIENT'S RELATIONSHIP TO THE PERSON NAMED ON ID CARD

○ SELF ○ SPOUSE ○ CHILD ○ OTHER

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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:

- ○ AUTOMOBILE ACCIDENT
- ○ WORK-RELATED ACCIDENT
- ○ OTHER: _____

DATE OF ACCIDENT

MM / DD / YYYY

DISABILITY DATES THRU

_____ _____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

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