

## 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.

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POLICYHOLDER INFORMATION  NAME ON ID CARD (first name, middle initial, last name)																														
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Signature:

OTHER INSURANCE COVERAGE INFORMATION (If You Have An Explanation of Benefits, Please Attach). If patient is continuous and the	
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,	DATE OF ACCIDENT
SHADE CIRCLE BELOW:	MM DD YYYY
O AUTOMOBILE ACCIDENT O WORK-RELATED ACCIDENT	DISABILITY DATES THRU
O OTHER:	THIC
DIAGNOSIS OR NATURE OF ILLNESS OR INJ	JRY
ASSIGNMENT OF BENEFITS: (Outside of Pennsy	rlvania only)
ATTENTION EMPLOYEE:	
This section applies to outside of Pennsylvania providers only. If PLEASE NOTE: A separate claim form is needed for each provi	der to whom you are assigning benefits.
I hereby authorize payment to the provider of surgical and /or me Employee Signature:	edical benefits, if any.  Date:
NOTE: PLEASE BE SURE THAT THE OUTSIDE PENNSYL	VANIA PROVIDER'S TAX CERTIFICATION NUMBER IS
PRINTED ON THE ITEMIZED BILL. IF TAX I.D. NUMBER EMPLOYEE/RETIREE.	R IS NOT PROVIDED, PAYMENT WILL BE SENT TO THE
CERTIFICATION:	
containing any materially false information or conceals for the purpose of	mpany or other person files an application for insurance or statement of claim of misleading, information concerning any fact material thereto commits a riminal and civil penalties. The signer agrees that any personally identifiable
health information about the signer or signer's enrolled dependents is pro-	otected by the Health Insurance Portability and Accountability Act of 1996 and I disclose Protected Health Information for treatment, payment and health care
	reby authorizes any insurer, employer, organization or health care service
	d on this claim form is correct and complete, and that I am claiming benefits

Date: