

PPO 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 <small>(Please see ID Card)</small>	
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.



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