MEDICAL CLAIM NOTICE

ADMINISTERED BY:

HealthSmart®

☐ **PLEASE CHECK IF NEW ADDRESS**

ENROLLEE: TO AVOID DELAYS, PLEASE FOLLOW THE INSTRUCTIONS BELOW.

1. COMPLETE FORM FOR EACH CLAIM SUBMISSION.
2. HAVE REVERSE SIDE OF THIS FORM COMPLETED BY PRIMARY PHYSICIAN (ASK OTHER PROVIDERS FOR ITEMIZED BILL & ATTACH TO THIS FORM).
3. MAIL YOUR CLAIMS TO THE CLAIMS MAILING ADDRESS PROVIDED ON THE BACK OF YOUR MEDICAL I.D. CARD.
4. IF YOU HAVE ANY QUESTIONS, CONTACT THE CUSTOMER SERVICE NUMBER ON YOUR MEDICAL I.D. CARD.

PART I: GROUP INFORMATION

GROUP NAME:	GROUP NUMBER:		
GROUP ADDRESS:	CITY	STATE	ZIP

PART II: ENROLLEE INFORMATION – COMPLETE FOR ALL CLAIMS

1. ENROLLEE NAME: FIRST MI LAST	2. SEX: ☐ M ☐ F	3. MEMBER ID:	4. DATE OF BIRTH: / /
5. HOME ADDRESS: STREET CITY STATE ZIP		6. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ LEGALLY SEPARATED	

7. HIRE DATE: / /	8. ARE YOU STILL ENROLLED IN PLAN? ☐ YES ☐ NO	9. IF NO, DATE OF TERMINATION: / /	10. DATE YOU BECAME RETIRED: / /	11. COBRA COVERAGE EFFECTIVE DATE: / /

12. ARE YOU ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO	13. DO YOU HAVE OTHER MEDICAL COVERAGE? ☐ YES ☐ NO	IF YES, COMPLETE BOXES #15 & #16 BELOW.

PART III: DEPENDENT INFORMATION – COMPLETE FOR ALL CLAIMS

14. DEPENDENT NAME	RELATIONSHIP TO ENROLLEE	SEX M-Male / F-Female	DATE OF BIRTH
	SPOUSE		
	CHILD		
	CHILD		
	CHILD		

15. WAS PATIENT COVERED BY ANY OTHER INSURANCE, MEDICARE OR AUTOMOBILE COVERAGE WHICH WOULD PAY FOR ANY MEDICAL EXPENSES OR DISABILITY LOSSES AT THE TIME CHARGES WERE INCURRED, EITHER AS AN EMPLOYEE, DEPENDENT OR MEMBER OF UNION OR OTHER ORGANIZATION?
☐ YES ☐ NO

16. COVERAGE PROVIDED THRU: ☐ SPOUSE ☐ CHILD ☐ OTHER PERSON ☐ PREVIOUS EMPLOYER

IF OTHER PERSON, NAME: _____ RELATIONSHIP: _____

INS. CO. NAME: _____

ADDRESS: _____

GROUP OR POLICY NUMBER: _____ CERTIFICATE NUMBER: _____

DATE CLAIM FILED WITH OTHER CARRIER: _____ ATTACH PAYMENT RECORD IF AVAILABLE

PART IV: CLAIM INFORMATION – COMPLETE FOR ALL CLAIMS

17. PATIENT'S NAME:	18. RELATIONSHIP TO ENROLLEE:	19. PATIENT'S SEX: ☐ M ☐ F	20. PATIENT'S DATE OF BIRTH: / /

21. IS CLAIM DUE TO: ☐ ILLNESS ☐ ACCIDENT (GIVE DESCRIPTION)	22. IS INJURY/ILLNESS RESULT OF EMPLOYMENT? ☐ YES ☐ NO	
IF ACCIDENT, COMPLETE THE FOLLOWING:	23. DATE AND TIME OF ACCIDENT:	24. LOCATION OF ACCIDENT:
25. CAUSE(S) OF ACCIDENT:		
26. WAS ILLNESS/INJURY CAUSED BY NEGLIGENCE OF THIRD PARTY? (i.e., BUSINESS ESTABLISHMENT, FAULTY PRODUCT, AUTO ACCIDENT) ☐ YES ☐ NO	27. IF AUTO ACCIDENT, IS NO-FAULT INSURANCE APPLICABLE? ☐ YES ☐ NO	

PART V: MANDATORY AUTHORIZATION SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE ANY PROVIDERS OF HEALTHCARE SERVICES, SUPPLIERS, CLAIM ADMINISTRATORS, INSURERS, REINSURERS AND OTHERS WHO HAVE A LEGITIMATE NEED FOR SUCH INFORMATION FOR THE PURPOSE OF REVIEW, INVESTIGATION OR EVALUATION OF A CLAIM TO SUPPLY EACH OTHER WITH THE INFORMATION ABOUT MY HEALTH STATUS AND HEALTHCARE SERVICES PROVIDED TO ME. I FURTHER AGREE TO REIMBURSE THE PLAN TO THE EXTENT OF ANY PAYMENT WHICH IS IN EXCESS OF THE AMOUNT PAYABLE UNDER THIS PLAN. I AGREE THAT A PHOTOCOPY OF THE AUTHORIZATION IS AS VALID AS THE ORIGINAL.

ENROLLEE'S SIGNATURE	**DATE**
SPOUSE'S SIGNATURE (FOR SPOUSE OR CHILD'S CLAIM)	**DATE**

PART VI:

TO BE COMPLETED BY ENROLLEE

PATIENT'S NAME AND ADDRESS:	**DATE OF BIRTH:**
AUTHORIZATION TO PAY BENEFITS TO THE PROVIDER. I hereby authorize payment directly to the Provider of the Surgical and/or Medical Benefits, if any, otherwise payable to me for the services as described below or on the attached bills, but not to exceed the reasonable and customary charge for those services.	**SIGNED (ENROLLEE):** **DATE:**
AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.	**SIGNED (ENROLLEE):** **DATE:**

TO BE COMPLETED & SIGNED BY ATTENDING PHYSICIAN

1. DATE OF: **ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)**	**2. DATE FIRST CONSULTED YOU FOR THIS CONDITION:**	**3. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?** ☐ YES ☐ NO	**4. IS CONDITION DUE TO EMPLOYMENT?** ☐ YES ☐ NO
5. DATE PATIENT IS ABLE TO RETURN TO WORK:	**6. DATE OF TOTAL DISABILITY:** **FROM:** **THROUGH:**	**7. DATE OF PARTIAL DISABILITY:** **FROM:** **THROUGH:**	
8. NAME OF REFERRING PHYSICIAN:	**9. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES:** **ADMITTED:** **DISCHARGED:**		
10. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)	**11. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?** ☐ YES ☐ NO **CHARGES:**		

12. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR ICD-10 CODE.

1.
2.
3.
4.

13. A. DATE OF SERVICE	**B.* PLACE OF SERVICE**	**C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN**		**D. ICD-10 DIAGNOSIS CODE**	**E. CHARGES**	
		PROCEDURE CODE (IDENTIFY)	**EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES**			

14. SIGNATURE OF PHYSICIAN OR SUPPLIER: **SIGNED:** **DATE:**	**15. ACCEPT ASSIGNMENT?** ☐ YES ☐ NO	**16. YOUR PATIENT'S ACCOUNT NUMBER:**	**18. TOTAL CHARGES:**		
			19. AMOUNT PAID:		
	17. YOUR EMPLOYER I.D. NUMBER:		**20. AMOUNT DUE:**		

21. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NUMBER:

***PLACE OF SERVICE CODES**

1-(IH):	Inpatient Hospital	4-(H):	Patient's Home	7-(NH):	Nursing Home	O-(OL):	Other Locations
2-(OH):	Outpatient Hospital	5-	Day Care Facility (PSY)	8-(SNF):	Skilled Nursing Facility	A-(IL):	Independent Laboratory
3-(O):	Physician's Office	6-	Night Care Facility (PSY)	9-	Ambulance	B-	Other Medical/Surgical Facility