

# HOW TO COMPLETE THIS MEDICAL CLAIM FORM

## 1. The Employee or Authorized Person must complete the following sections of the Benefit Claim Form:

- Employee Information
- Patient Information
- Accident Information
- Medicare Information
- Other Health Insurance
- Authorization/Release of Information

*This claim cannot be processed unless all sections are completed. Claims for services provided by a nonparticipating provider must be submitted on this Benefit Claim Form.*

## 2. Assignment of Benefits

If the provider is **not** a Participating Provider, the decision whether or not to assign benefits is between you and the provider.

## 3. Submitting the Claim Form

If the provider is **not** a Participating Provider, you are responsible for filing the claim.

### Send claims to:

**Carelink** – PO Box 7373, London, KY 40742

**CHC of the Carolinas** – PO Box 7715, London, KY 40742

**CHC of Georgia** – PO Box 7711, London, KY 40742

**CHC of Iowa** – PO Box 7709, London, KY 40742

**CHC of Kansas, Kansas City** – PO Box 7109, London, KY 40742

**CHC of Kansas, Wichita** – PO Box 7124, London, KY 40742

**CHC of Louisiana** – PO Box 7707, London, KY 40742

**CHC of Nebraska** – PO Box 7705, London, KY 40742

**Group Health Plan (GHP)** – PO Box 7374, London, KY 40742

**HealthAmerica/HealthAssurance (Central PA)** – PO Box 7089, London, KY 40742

**HealthAmerica/HealthAssurance (Western PA)** – PO Box 7088, London, KY 40742

**WellPath Select, Inc.** -- PO Box 7102, London, KY 40742

Carelink  
CHC of Kansas, Kansas City  
Group Health Plan (GHP)

(Please circle or highlight your Coventry Health Care, Inc. plan name)

CHC of the Carolinas  
CHC of Kansas, Wichita  
HealthAmerica/HealthAssurance

CHC of Georgia  
CHC of Louisiana  
WellPath Select, Inc.

CHC of Iowa  
CHC of Nebraska

# Medical Claim Form

Please print

## Employee Information

SEE PAGE 1 FOR INSTRUCTIONS ON HOW TO COMPLETE THIS CLAIM FORM

Last Name	First	MI	Member ID Number
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## Patient Information

 Complete this section only if claim is for a qualified dependent.

Last Name	First	MI	If age 19 or over <input type="checkbox"/> Student <input type="checkbox"/> Disabled If student, give name of school, city and state
Member Number/Suffix	Date of Birth	Relationship	Sex

## Accident Information

 Complete this section only if claim is result of accident or work related illness or injury.

Date of accident or first symptoms of illness?	Where did the accident occur? (City/State)	Is accident/illness related to employment? If no, <input type="checkbox"/> Auto <input type="checkbox"/> Other
Describe the accident or illness.	Give date patient first consulted physician.	Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Medicare Information

 Complete this section only if patient is eligible for Medicare.

Please attach copy of the "Explanation of Benefits" statement from your Medicare Insurance carrier.	Medicare Number	Effective Date Part A	Effective Date Part B
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## Other Health Insurance or HMO Coverage

 If Yes, complete section below or claim cannot be processed.  No other coverage

Name of Policyholder	Policy Number	Name of Insurance Company	
Street Address	City	State	Zip

## Authorization/Release of Information

I authorize any insurance company, organization, employer, hospital physician, pharmacist or other health care provider to release any information requested with regard to this claim and the expenses reported. I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to omit facts I know are important.

Patient or authorized person's signature \_\_\_\_\_ Date \_\_\_\_\_

I agree to assign benefits directly to the provider of services: \_\_\_\_\_  
Patient or authorized person's signature \_\_\_\_\_ Date \_\_\_\_\_

**!!!! THIS SECTION INTENDED FOR PHYSICIANS ONLY !!!!**  
**IF A DETAILED STATEMENT IS AVAILABLE, PLEASE ATTACH.**

## Provider Statement of Services Rendered

Name and Address of Facility where services were rendered (If other than home or office)			Date Admitted	Date Discharged		
Diagnosis Code and Description 1. 2.						
Date of Service From/To	Place of Service	CPT-4 Procedure Code	Description of Service	Charges	Days or Units	
Signature of Provider			Total Charge	Amount Paid	Balance Due	

Provider Name	Tax I.D. Number
Provider Address	Telephone Number

**Please mail this completed form to:  
The claim address listed next to the  
name of your health plan listed on  
the attached page.**