Medical Claim Form

Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing. See reverse side for complete instructions.

PATIENT INFORMATION

Member ID (from Health Plan ID Card)_____ Group Number _____

Name (Last, First, MI) _____ Date of Birth ___ /___ /_____

Address _____ Relationship to Subscriber: (Select One)

City _____ State ____ Zip Code _____ __ Subscriber __ Spouse

Phone # _____ __ Child __ Other Dependent

SUBSCRIBER INFORMATION (Complete this section if different from patient)

Subscriber Name (Last, First, MI)_____ Date of Birth ___ /___ /_____

Address _____ Phone # _____

City _____ State ____ Zip Code _____

PROVIDER INFORMATION (This information is required to process the claim. Ask your provider to complete)

Provider Name: _____ Provider Tax ID _____

NPI Number _____ Group/Facility Name _____

Address _____ Phone # _____

City _____ State ____ Zip Code _____

Address (Services Rendered) _____

MEDICAL SERVICE INFORMATION (Use this section to report medical services provided or Attach Superbill)

Date of Service	Diagnosis Code ICD10	Procedure Code (CPT/HCPC) w/ Modifier	Number Units	Charge

By signing below, I am stating to the best of my knowledge, that the information above is true and correct.

Signature _____ **Date** ___ / ___ / _____

To ensure faster processing of your claim, be sure to do the following:

If you write on the form, use black or blue ink and print clearly and legibly. You can also use your computer to complete this form and then print it out to mail to us.

Complete all of the applicable fields on the form. Ask your provider for the Provider Information or have them fill that section out for you.

Complete a separate claim for each covered family member.

Complete a separate claim for each provider.

If you have other insurance or Medicare and it is primary to your plan with us, please include the explanation of benefits (EOB) from your other insurance or Medicare.

Ask your provider to complete the Provider Information section on the form (below). All the information in that section is required to process the claim.

Ask your provider to complete the Medical Information section (below) or give you a Superbill or Invoice that includes all the following for each date of service:

IMPORTANT: This information must be on the Superbill and is required to process the claim. Missing information can result in delay or non-payment of the claim. Please be sure the information is clear and readable.

- Patient Name
- Diagnosis Codes (Must use ICD10 codes)
- Procedure Codes (CPT, HCPC) - include any applicable modifiers
- Units for each procedure code
- The billed amount for each procedure code
- Place of Service Code

Once you have completed this form, mail it to the address listed below:
PO Box 576
Arnold, MD 21012

Be sure to attach the Superbill and any receipts of your payment.