Independence

MEDICAL CLAIM FORM

Claims Receipt Center
P.O. Box 211184
Eagan, MN 55121

TO BE COMPLETED BY PATIENT

PATIENT INFORMATION:

1. PATIENT'S NAME (LAST) (FIRST) (MIDDLE INITIAL)

2. PATIENT'S ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)

3. MEMBER IDENTIFICATION NUMBER

4. PATIENT'S PHONE NUMBER ( ) AREA CODE

5. PATIENT'S BIRTH DATE MONTH | DAY | YEAR

6. PATIENT'S SEX ❑ MALE ❑ FEMALE

7. PATIENT'S RELATIONSHIP TO MEMBER ❑ SELF ❑ SPOUSE ❑ CHILD

8. DIAGNOSIS OR NATURE OF ILLNESS

9. WAS AN ACCIDENT INVOLVED? ❑ YES ❑ NO
IF YES WHEN? MONTH | DAY | YEAR
WHERE: ❑ AUTO ❑ WORK ❑ OTHER:

ENCLOSE A BRIEF DESCRIPTION OF HOW AND WHERE ACCIDENT OCCURRED

OTHER COVERAGE:

10. IS THE PATIENT COVERED BY ANY OTHER INSURANCE PLAN? ❑ YES ❑ NO

IF YES — NAME OF INSURANCE COMPANY | POLICY NUMBER

ADDRESS OF INSURANCE COMPANY

11. IS THE PATIENT ELIGIBLE FOR MEDICARE? ❑ YES ❑ NO

IF YES — MEDICARE PART A EFFECTIVE DATE MONTH / DAY / YEAR

MEDICARE PART B EFFECTIVE DATE MONTH / DAY / YEAR

PATIENT'S SIGNATURE:

13. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, The Health Plan may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices.

X PATIENT'S SIGNATURE:_____ **DATE:** _____

If your provider is in-network, the provider will submit a claim for you.
This claim form should be submitted only when you use a non-network provider who does not submit the claim for you.

PHYSICIAN OR SUPPLIER INFORMATION

1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBER 1, 2, 3, ETC. OR DX CODE

1
2
3
4

2. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) PROCEDURE CODE (IDENTIFY)		D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. LEAVE BLANK

3. HAS FEE BEEN PAID?	4. TOTAL CHARGE	5. AMOUNT PAID	6. BALANCE DUE
YES NO			

7. PHYSICIAN'S OR ACCOUNT'S NAME, ADDRESS, ZIP CODE & PROVIDER NO.

PLACE OF SERVICE CODES

1 — (IH) — Inpatient Hospital
2 — (OH) — Outpatient Hospital
3 — (O) — Doctor's Office
4 — (H) — Patient's Home
5 — — Day Care Facility (PSY)
6 — — Night Care Facility — (PSY)
7 — (NH) — Nursing Home
8 — (SNF) — Skilled Nursing Facility
9 — — Ambulance
0 — (OL) — Other Locations
A — (IL) — Independent Laboratory
B — — Other Medical Surgical Facility
C — (RTC) — Residential Treatment Center
D — (STF) — Specialized Treatment Facility