

Health Claim Form



MERITAINSM
HEALTH

Complete and send to:
Meritain Health
P.O. Box 27267
Minneapolis, MN 55427-0267
Fax: 1.763.852.5016
Email: SCPMG.Claims@meritain.com

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work-related claim.

Section 1. EMPLOYEE INFORMATION						
Name (last, first, initial)			Sex	Employer Name		
Home Address			Identification Number		Birthdate	Group Number
City	State	Zip Code	Work Telephone ()		Home Telephone ()	
Section 2. PATIENT INFORMATION						
The patient is:	<input type="checkbox"/> The employee (Go to section 3)	<input type="checkbox"/> Employee's Spouse (Complete spouse information)	<input type="checkbox"/> Employee's Child (Complete spouse and child information)			
Spouse's Name (last, first, initial)		Sex	Child's Name (first, last, initial)		Sex	
Spouse's Birthdate		Spouse's Social Security Number		Child's Birthdate		
Spouse's Employer		<i>If child is over age 19 and full-time student, complete:</i> Name of School:				
Spouse's Employer's Address		School Address				
Section 3. OTHER COVERAGE						
<input type="checkbox"/> Yes (then complete) <input type="checkbox"/> No (go to section 4)			Name of Policy Holder:			
Name of Other Health Insurance Carrier or Plan		Address		City	State Zip Code	
Other Insurance Carrier's or Plan's Telephone #		Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual		Group Number Contract or Policy Number		
Spouse's Employer		<i>If child is over age 19 and full-time student, complete:</i> Name of School:				
Spouse's Employer's Address		School Address				
Section 4. ABOUT THIS CLAIM						
<input type="checkbox"/> Injury <input type="checkbox"/> Illness		Describe injury, when and how it happened or nature of illness:				
Date and time of accident:						
Was this injury the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If auto insurance was involved, please provide:			Policy #	Name of insurance company	Address (city, state, zip)	
Was this a work-related injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			<i>If injury is work-related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.</i>			
EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED						
The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.						
Signature:					Date:	
ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)						
I authorize payment of benefits to the doctor or supplier of services listed here.						
Provider to be paid			Employee's Signature			
Provider's tax ID number or Social Security Number			Date			



IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill.

A	Patient Name (last, first, initial)	Birthdate																																									
B	Address																																										
C	Is this condition the result of an injury arising from patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please contact the Worker's Compensation Carrier/Administrator for proper instruction regarding this claim.</i>																																										
D	Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, expected date of delivery																																									
E	If illness, date of first treatment	If treating injury, date of injury																																									
F	Name of referring physician	Referring physician's address																																									
G	Name and facility where services were rendered (if other than home or office)																																										
H	Was laboratory work performed outside your office? <input type="checkbox"/> Yes <input type="checkbox"/> No																																										
I	For service related to hospitalization, give dates: <input type="checkbox"/> Admitted <input type="checkbox"/> Discharged																																										
J	Diagnosis and current conditions (if diagnosis other than ICD-9* used, give name): 1. 2. 3. 4.																																										
K	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Dates of Service From To</th> <th style="width:10%;">Places of Services**</th> <th style="width:15%;">Procedure Code (If other than CPT*** code used, give name)</th> <th style="width:40%;">Description of surgical or medical services rendered</th> <th style="width:10%;">Diagnosis Code</th> <th style="width:10%;">Charges</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p><small>*ICD-9 * International Classification of Disease **Abbreviations: 11-Physician's Office 12-Inpatient Hospital 23- Emergency Room *** CPT Current Procedural Terminology (current edition) 12-Patient's Home 22-Outpatient Hospital 81-Independent Laboratory</small></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">Date</td> <td style="width:40%;">Physician's Name (print)</td> <td style="width:20%;">Degree</td> <td rowspan="2" style="width:20%; text-align:center; vertical-align:top;">Provider's Tax ID Number or Social Security Number: Must be furnished under authority of law</td> </tr> <tr> <td colspan="3">Physician's Signature</td> </tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:45%;">Street Address</td> <td style="width:20%;">City</td> <td style="width:10%;">State</td> <td style="width:25%;">Zip Code</td> </tr> </table>		Dates of Service From To	Places of Services**	Procedure Code (If other than CPT*** code used, give name)	Description of surgical or medical services rendered	Diagnosis Code	Charges																									Date	Physician's Name (print)	Degree	Provider's Tax ID Number or Social Security Number: Must be furnished under authority of law	Physician's Signature			Street Address	City	State	Zip Code
Dates of Service From To	Places of Services**	Procedure Code (If other than CPT*** code used, give name)	Description of surgical or medical services rendered	Diagnosis Code	Charges																																						
Date	Physician's Name (print)	Degree	Provider's Tax ID Number or Social Security Number: Must be furnished under authority of law																																								
Physician's Signature																																											
Street Address	City	State	Zip Code																																								

STATUS AND BENEFIT INFORMATION:
1.888.711.7876

Send to:
Meritain Health
P.O. Box 27267
Minneapolis, MN 55427-0267
Fax: 1.763.852.5016
Email: SCPMG.Claims@meritain.com