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 Health Plans, Inc. - PO Box 7373, London, KY 40742

CHC of Georgia - PO Box 7711, London, KY 40742

CHC of Iowa - PO Box 7709, London, KY 40742

CHC of Kansas - PO Box 7109, London, KY 40742

CHC of Louisiana - PO Box 7707, London, KY 40742

CHC of Nebraska - PO Box 7705, London, KY 40742

Coventry Health Care of the Carolinas, Inc. - PO Box 7102, 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
### Medical Claim Form

**Please print**

**Employee Information**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>MI</th>
<th>Member ID Number</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>MI</th>
<th><strong>If age 19 or over</strong></th>
<th><strong>Student</strong></th>
<th><strong>Disabled</strong></th>
<th><strong>If student, give name of school, city and state</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member Number/Suffix</th>
<th>Date of Birth</th>
<th><strong>Relationship</strong></th>
<th><strong>Sex</strong></th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th><strong>Date of accident or first symptoms of illness?</strong></th>
<th><strong>Where did the accident occur?</strong> (City/State)</th>
<th><strong>Is accident/illness related to employment?</strong></th>
<th><strong>If no,</strong></th>
<th><strong>Auto</strong></th>
<th><strong>Other</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Describe the accident or illness.</strong></th>
<th><strong>Give date patient first consulted physician.</strong></th>
<th><strong>Has patient ever had same or similar symptoms?</strong></th>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th><strong>Medicare Number</strong></th>
<th><strong>Effective Date Part A</strong></th>
<th><strong>Effective Date Part B</strong></th>
</tr>
</thead>
</table>

**Other Health Insurance or HMO Coverage** If Yes, complete section below or claim cannot be processed. **No other coverage**

<table>
<thead>
<tr>
<th><strong>Name of Policyholder</strong></th>
<th><strong>Policy Number</strong></th>
<th><strong>Name of Insurance Company</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Street Address</strong></th>
<th><strong>City</strong></th>
<th><strong>State</strong></th>
<th><strong>Zip</strong></th>
</tr>
</thead>
</table>

**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**

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**!!!!! THIS SECTION INTENDED FOR PHYSICIANS ONLY !!!!!**

**IF A DETAILED STATEMENT IS AVAILABLE, PLEASE ATTACH.**

**Provider Statement of Services Rendered**

<table>
<thead>
<tr>
<th><strong>Name and Address of Facility where services were rendered (if other than home or office)</strong></th>
<th><strong>Date Admitted</strong></th>
<th><strong>Date Discharged</strong></th>
</tr>
</thead>
</table>

**Diagnosis Code and Description**

1.  
2.

<table>
<thead>
<tr>
<th><strong>Date of Service</strong></th>
<th><strong>Place of Service</strong></th>
<th><strong>CPT-4 Procedure Code</strong></th>
<th><strong>Description of Service</strong></th>
<th><strong>Charges</strong></th>
<th><strong>Days or Units</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Signature of Provider</strong></th>
</tr>
</thead>
</table>

**Provider Name**

**Tax I.D. Number**

**Provider Address**

**Telephone Number**

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