COVENTRY Health Care

*Please print*

**Employee Information** SEE REVERSE SIDE FOR INFORMATION ON HOW TO FILE A CLAIM

| Last Name | First | MI | Social Security Number |
|---|---|---|---|
| | | | |

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

| Last Name | First | MI | If age 19 or over ☐ Student ☐ Disabled<br>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, ☐ Auto ☐ Other |
|---|---|---|
| Describe the accident or illness. | Give date patient first consulted physician. | Has patient ever had same or similar symptoms? ☐ Yes ☐ 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 |
|---|---|---|---|

**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

# Benefit Claim Form

**IF DETAIL STATEMENT IS AVAILABLE, PLEASE ATTACH. DO NOT FILL OUT LOWER PORTION.**

**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 | |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | Total Charge | Amount Paid | Balance Due |

Signature of Provider

Provider Name Tax I.D. Number

Provider Address Telephone Number

**Please mail completed form to:**
CHC of Illinois, Inc.
P.O. Box 7141
London, KY 40742-7141

# HOW TO COMPLETE THIS BENEFIT 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.

   Mail the completed Benefit Claim Form to:
   CHC of Illinois, Inc.
   Attn: Claims Department
   P.O. Box 7141
   London, KY 40742-7141

4. **Additional Benefit Claim Forms may be obtained from your employer, through My Online Services at https://member.cvty.com or by contacting Coventry Health Care of Illinois at (800) 431-1211.**