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

(Please circle or highlight your Coventry Health Care, Inc. plan name)

Carelink Health Plans, Inc.	CHC of Kansas, Kansas City	CHC of Nebraska	HealthAmerica/HealthAssurance
CHC of Georgia	CHC of Kansas, Wichita	Coventry Health Care of the Carolinas, Inc.	
CHC of Iowa	CHC of Louisiana	Group Health Plan (GHP)	

Medical Claim Form

Please print

Employee Information **SEE PAGE 1 FOR INSTRUCTIONS ON HOW TO COMPLETE THIS CLAIM FORM**

Last Name	First	MI	Member ID 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 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

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

IF A DETAILED STATEMENT IS AVAILABLE, PLEASE ATTACH.

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