MedBen
Where peace of mind is your best benefit®

MEDICAL CLAIM FORM

TO BE COMPLETED BY ENROLLED EMPLOYEE
(ALL QUESTIONS MUST BE ANSWERED)

SEND CLAIMS DIRECTLY TO:
MedBen
P.O. Box 1129 • Newark, Ohio 43058-1129
(740) 522-8425 • Toll-Free (800) 423-3151

A NEW MEDICAL CLAIM FORM NEEDS TO BE COMPLETED ONCE EVERY YEAR.

PATIENT INFORMATION

1. PATIENT NAME - LAST NAME, FIRST NAME, MIDDLE INIT.

2. PATIENT DATE OF BIRTH ____/____/____ 3. PATIENT SEX MALE ☐ FEMALE ☐

4. RELATION TO EMPLOYEE SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

5. ENROLLED EMPLOYEE NAME AS SHOWN ON CARD _____

ADDRESS _____

_____ CHECK IF CHANGE ☐

6. GROUP # _____

7. EMPLOYEE I.D. NUMBER ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

EMPLOYEE MARTIAL STATUS MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐

8. IS PATIENT EMPLOYED? YES ☐ NO ☐
IF YES: NAME OF EMPLOYER _____

ADDRESS OF EMPLOYER _____

_____

_____ TELEPHONE NUMBER _____

OTHER HEALTH INSURANCE ON THIS PATIENT YES ☐ NO ☐
IF YES: NAME AND ADDRESS OF OTHER INSURER _____

_____

_____

TELEPHONE NUMBER _____

NAME OF ENROLLED EMPLOYEE FOR OTHER COVERAGE _____ RELATIONSHIP TO PATIENT SELF ☐ SPOUSE ☐ OTHER ☐

SUBSCRIBER I.D. NO. _____ MEDICARE: YES ☐ NO ☐ MEDICARE DISABILITY: YES ☐ NO ☐ EFFECTIVE DATE _____

9. CLAIM IS FOR: ILLNESS ☐ INJURY ☐ DESCRIBE CONDITION OR ILLNESS:

_____

_____

_____

_____

DATE PATIENT BECAME DISABLED OR FIRST DATE OF SYMPTOMS _____
IF CONDITION IS THE RESULT OF AN ACCIDENT:
TYPE OF ACCIDENT: ON THE JOB ☐ AUTO ACCIDENT ☐ OTHER ☐

DATE OF ACCIDENT _____

DESCRIBE THE ACCIDENT _____

10. IF PATIENT IS A DEPENDENT CHILD BETWEEN 19 AND 25, IS HE/SHE A FULL TIME STUDENT? YES ☐ NO ☐ NUMBER OF CREDIT HOURS _____

IF YES: NAME OF SCHOOL _____ TELEPHONE NUMBER _____

ADDRESS _____

11. IS PATIENT A MINOR IN THE CUSTODY OF A PERSON OTHER THAN THE EMPLOYEE? YES ☐ NO ☐
IF SO, PLEASE LIST THE NAME AND ADDRESS OF THE PERSON WITH LEGAL CUSTODY OF THE PATIENT. _____

_____

RELEASE OF INFORMATION - PATIENT OR AUTHORIZED PERSON'S SIGNATURE

I authorize (1) any physician, hospital, or other health practitioner or facility, (2) any insurance company or health care plan, (3) any state or federal agency providing health care benefits, and (4) any employer to provide MedBen or their legal representative any information in their possession which is relevant to this claim or to the specific treatment or condition(s) for which I am being treated. This information will be used to determine the benefits payable and will be utilized by employees and agents of MedBen with responsibility for review and payment of claims. I hereby authorize any provider of health care services, claim administrators, insurers, reinsurers, stop loss carriers and others who have a legitimate need for such information for the purpose of review, investigation, or evaluation of a claim, to supply each other with information about the health status of, and health care services provided to, the patient. This authorization is effective on the date signed and shall remain in effect for the term of my coverage under the plan of benefits administered by MedBen. (You or any individual authorized by law to act on your behalf have a right to receive a copy of this authorization). A photographic copy of this authorization shall be as valid as the original.

_____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE - DATE

AUTHORIZATION OF PAYMENT - I authorize the payor at its option to issue payment to the provider(s) indicated on this claim.

_____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE - DATE

WARNING: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER OR HEALTH BENEFIT PLAN, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE OR HEALTH CARE FRAUD UNDER STATE AND/OR FEDERAL LAW.

DO NOT WRITE BELOW THIS LINE — PHYSICIAN'S USE ONLY

PHYSICIAN/PROVIDER INFORMATION

DATE OF
ILLNESS _____ (First Symptom)
INJURY _____ (Accident Date)
PREGNANCY _____ (LMP)

DATE FIRST CONSULTED YOU FOR THIS CONDITION

DATE OF PREVIOUS TREATMENT FOR THIS CONDITION

IF EMERGENCY CHECK HERE ☐

DATE ABLE TO RETURN TO WORK

DATE OF TOTAL DISABILITY OR PARTIAL DISABILITY (CHECK ONE) ☐ ☐
FROM THROUGH

FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGE

NAME OF REFERRING PHYSICIAN

WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? CHARGES

NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1. 2. 3. OR DX CODE
A. 1. 2. 3.

B. DATE OF SERVICE	C. PLACE OF TREAT-MENT	D. PROCEDURE CODE (IDENTIFY)	E. FULLY DESCRIBE PROCEDURE, MEDICAL, SERVICE OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	F. DIAGNOSIS CODE	G. CHARGES	H. DAYS OR UNITS	I. TYPE OF SERVICE

SIGNATURE OF PHYSICIAN OR SUPPLIER	PATIENT ACCOUNT NO.	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE

YOUR SOCIAL SECURITY NO.	YOUR EMPLOYER I.D. NO. *(CLAIM CANNOT BE PROCESSED W/O)*

PLACE OF SERVICE CODES
1 (IH) - Inpatient Hospital
2 (OH) - Outpatient Hospital
3 (O) - Doctor's Office
4 (H) - Patient's Home

SECOND SURGICAL OPINION:
OPINION CONFIRMED YES ☐ NO ☐
NAME OF FIRST OPINION PHYSICIAN:

PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS ZIP CODE & TELEPHONE

INSTRUCTIONS FOR FILING YOUR MEDBEN CLAIM

Please take time to familiarize yourself with these instructions. Proper completion of the form by you will prevent unnecessary delays in processing your claim. All incomplete forms will be returned.

I. Complete the top section indicated on the left margin as Patient Information. If your claim does not involve physician charges and consists only of your itemized bills for drugs or other such services, just attach your bills to the claim form and disregard the bottom section.

II. Please submit a separate claim form for each patient. You can send as many bills as you wish for each claim form as long as those bills are for the same person. PLEASE ATTACH ITEMIZED BILLS.

III. Keep a copy of the bills for your records. This can prevent you from inadvertently filing duplicate claims.

IV. Provide us with details of any accident in Section 9. Let us know how the accident occurred, where it occurred, the date of the accident, and the nature of the injuries in your own words. Feel free to attach a separate sheet of paper, if necessary.

V. If you are also covered by another health insurer, Blue Cross/Blue Shield plan, HMO, Medicare, or other governmental agency, please be sure to attach a copy of that Company's Explanation of Benefits to this claim. Check the Explanation of Benefits form to be sure that it is for the same date(s) of service, provider, and charges that you are submitting on this claim.

VI. Precertification requirements. If you or your covered dependent face a surgical procedure or facility admission in the near future that requires precertification (as detailed in your Summary Plan Document), you must notify the Utilization Review Department listed on your ID card as soon as you are aware of the anticipated service, but not later than 48 hours prior to your treatment or admission or as soon as reasonably possible for transplant surgery. Notice can be provided by telephone at any hour of the day or night. Your physician may provide the notice for you, but the primary responsibility for ensuring that we are notified rests with you. You are also required to provide us with notice within 48 hours after any emergency or non-scheduled admission to a hospital. FAILURE TO PROVIDE NOTICE AS REQUIRED COULD CAUSE A SUBSTANTIAL REDUCTION IN YOUR BENEFITS, AS DESCRIBED IN THE COST CONTAINMENT SECTION OF YOUR CERTIFICATE BOOKLET.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer or health benefit plan, submits an application or files a claim containing a false or deceptive statement is guilty of insurance or health care fraud under state and/or federal law.