Deaconess OneCare HEALTH PLAN

Claim Form

USE SEPARATE FORM FOR EACH PATIENT

General instructions: Make sure you and your physician or other health care professional fill out this form completely in order for you to receive timely reimbursement for paid medical services.

- Type or print requested information.
- Ask your provider(s) to help you complete all information in sections C and D.
- Attach itemized receipts or claim forms for each service. (Do not staple items.)
- A separate reimbursement request form should be completed for each patient.
- Please keep a copy of each itemized bill or receipt for your records.
- Do not submit a form if your physician or other health care professional is also filing a claim to Deaconess OneCare for the same service.

GROUP NO. (FROM I.D. CARD)

MEMBER IDENTIFICATION NO. (FROM I.D. CARD)

A. PATIENT INFORMATION

PATIENT NAME (Print) _____ SEX ☐ M ☐ F BIRTHDATE _____

RELATIONSHIP TO EMPLOYEE : ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER _____

B. EMPLOYEE INFORMATION

EMPLOYEE NAME _____ Check if new address ☐

EMPLOYEE ADDRESS_____City_____State_____ Zip_____

C. PROVIDER INFORMATION

PROVIDER NAME_____TAX ID NUMBER_____NPI NUMBER_____

PROVIDER ADDRESS_____City_____State_____ Zip_____

D. SERVICE INFORMATION

Date (mm/dd/yy)	Place of Service	Codes for procedures, services or supplies	Diagnosis Code	Charges	Number of Units
				Total Charges	**Amount paid by you**

Over (please complete both pages) →

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E. OTHER INSURANCE INFORMATION

IS PATIENT COVERED BY ANOTHER MEDICAL PLAN? ☐ YES ☐ NO

IF YES, INDICATE MEDICAL PLAN NAME _____ POLICY NUMBER _____

IDENTIFICATION NUMBER _____ EFFECTIVE DATE OF COVERAGE _____

NAME, ADDRESS AND PHONE # OF OTHER CARRIER _____

EMPLOYER'S NAME _____ Phone _____ EMPLOYEE BIRTH DATE _____

SPOUSE'S BIRTH DATE _____

IF YOU ARE ELIGIBLE FOR MEDICARE:

- Submit bills for all charges except prescription drugs to Medicare first. Make sure you keep a copy of the itemized bill, since you will also need to submit it to Deaconess OneCare.
- You will receive the Explanation of Benefits Statement from Medicare, indicating payment or denial of your claim submission. Submit the Medicare statement and a copy of itemized bill to Deacones Onecare.
- Some physicians and other medical providers will file your Medicare claims directly for you. You need to tell them to send you a copy of the itemized bill also, since you need to send it to Deaconess OneCare once you receive Medicare's Explanation of Benefits.

F. PATIENT AUTHORIZATION

To all physicians and other medical professionals, hospitals and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit administrators:

- You are authorized to provide any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on Deaconess OneCare's behalf, with information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.
- I hereby authorize Deaconess OneCare to provide the information relating to medical services and treatment rendered to me and/or my dependents.
- I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.
- I have furnished the information on this form so that Deaconess OneCare may consider this claim. By signing below, I certify the information is correct and the expenses were incurred by the patient named above.
- Should there be an overpayment in excess of the amount payable under the Medical Plan, I agree to reimburse Deaconess OneCare to the extent of the overpayment.

_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE RELATIONSHIP OF AUTHORIZED PERSON DATE

G. PAYMENT AUTHORIZATION

PAY TO PROVIDER

☐ I authorize benefits to be paid directly to the physician or other provider of service.

EMPLOYEE / RETIREE / SURVIVOR SIGNATURE DATE

PAY TO ME

☐ I authorize benefits to be paid to me. I understand it is my responsibility to pay the physician, hospital, or other provider of service.

EMPLOYEE / RETIREE / SURVIVOR SIGNATURE DATE

Before you submit your claim…..

1. Be sure that all fields are completed.
2. Make photocopies of all receipts and completed forms. Receipts will not be returned.
3. Write your Member ID number on all paperwork you submit.

SUBMIT TO:

P.O. Box 407, Columbus, IN 47202-0407
Call Local: 812-378-7103 or
Toll Free: 844-378-7103