

Provider Name

Tax I.D.#

Provider Address

Telephone #

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 that apply are completed. Claims for services provided by a nonparticipating provider **must** be submitted on this benefit claim form.

2. Submitting the claim form: If the provider is a nonparticipating provider, you are responsible for filing the claim.

Mail the completed Benefit Claim Form to:

Central and Eastern Pennsylvania
HealthAmerica Claims
P.O. Box 7089
London, KY 40742

Western Pennsylvania & Ohio
HealthAmerica Claims
P.O. Box 7088
London, KY 40742

3. Additional Benefit Claim Forms may be obtained from your employer, by contacting HealthAmerica or by downloading a claim form at www.healthamerica.cvty.com.

If you have any questions, call Customer Service at **1-800-735-4404** in western Pennsylvania and Ohio, or **1- 800-788-8445** in central and eastern Pennsylvania.