

10/1/04

BENEFIT CLAIM FORM

For PPO and POS Members

Current Address:	Last	First		MI	Social Security Number	Date	e of Birth	Male	
	Street	City	State	Zip	Daytime Phone No	Marital	·· Single	Female Widowed	
Employer Name		Street		(City	Status State	Married I	Divorced	
						Saire			
tient Informati	ion - Complete	this section only if cla	aim is for a c	qualified d	ependent.				
Name:	Last	First		MI			If age 19 or over Student Disabled If Student, Name of School, City and State:		
Social Security No.	Date of Birth Relationship		ı	·· Male ·· Female					
ccident Informs	a tion - Complet	e this section only if	claim is resu	lt of Accid	lent or work related	d Illness o	r Injury		
Date of Accident or first		Where did the Accident occ		Is Accident/I	llness related to employmer		Date patient fir		
Describe Accident Or Illness:				Auto Accident Other			Has patient eve	physician for the condition: Has patient ever had same or simila symptoms? "Yes "No	
							symptoms:	ies No	
		te this section only if efits" statement from your	patient is eli			tive Date Part	A Effectiv	e Date Part B	
Medicare Insurance Carr		ans statement from your		Wedicai	e Number Effec	tive Date I ait.	A Effectiv	C Date I alt B	
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Name of Policyholder	Policy Number	O Coverage - This cl		be process Addi		On 18 COM	State	Zip	
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uthorization/Re	elease of Inform	nation							
If certify that the informative Environment PENNSYLVANIA: A application for insurance misleading, information of subjects such person to croohio: Any person who,	ation furnished in conju- ny person who knowing or statement of claim co- concerning any fact mat- riminal and civil penalti , with intent to defraud	with regard to this claim and the nction with the claim is true and gly and with intent to defraud an ontaining any materially false in erial thereto commits a fraudule les. or knowing that he is facilitating deceptive statement is guilty of an and the properties of the statement is guilty of an an a	d correct. The insurance companion or concent insurance act, where the insurance act, where it is a fixed against an insurance act.	any or other per eals for the purp which is a crime	oose of and	ent or Authoriz	ed Person's Signatu	re Date	
apprication of fries a cital									
	benefits directly	to the provider of ser	vices:						
	benefits directly	to the provider of ser		oyer or Au	thorized Person's S	Signature		Date	
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HOW TO FILE A CLAIM

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.

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