MAIL COMPLETED CLAIM FORM TO:
The address listed on your ID Card

Medical Claim Form

Please refer to instructions on the back of this form. A properly completed form will expedite the processing of your claim.

I. COMPLETE FOR ALL MEDICAL CLAIMS

Insured's ID Number (shown on ID Card)	**Insured's Name (Last, First, Middle)**
Insured's Address (Street, City, State, ZIP Code)	

II. COMPLETE FOR DEPENDENT CLAIMS ONLY

Dependent Name (Last, First, Middle)	**Relationship to Insured**	
Dependent's Other Coverage (if applicable)	**ID Number** (shown on ID Card)	**Date of Birth**

III. COMPLETE FOR ACCIDENT-RELATED CLAIMS ONLY

How, when and where did the accident occur?		
Was someone else at fault? If yes, please explain.		
Did the accident happen during the course of employment? If so, has a Workers' Compensation claim been filed?	☐ Yes ☐ No ☐ Yes ☐ No	**Name of Employer**

IV. COMPLETE FOR ALL MEDICAL CLAIMS (Authorization)

I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide HealthSCOPE Benefits, or an agent, attorney, consumer reporting agency or independent administrator acting on its behalf, information concerning advice, care or treatment provided to the patient, insured or deceased named below, including information relating to mental illness, use of drugs, or use of alcohol. I understand that HealthSCOPE Benefits' will use such information for the purpose of evaluating my claim for benefits and that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim. I agree that a photostatic copy of this authorization shall be valid as the original.

I authorize HealthSCOPE Benefits to directly reimburse the provider whose bills are attached. ☐ Yes ☐ No
(*Selecting "Yes" means payment will be sent to the provider directly instead of the insured.*)

Patient Signature (if over 18 years of age) / Patient's Representative (if under 18 years of age)	Date Signed (Mo/Day/Year)

Please review the instructions on Page 2. You must attach your bills to this form for your claim to be considered.

(OVER)

Medical Claim Form Instructions

1. **Use a separate claim form for each family member.** If the bill shows expenses for more than one family member, highlight the name of the patient for whom this claim is being submitted.

2. **Complete the applicable Sections of the claim form for each claim.**

3. **All bills must be itemized and include the patient's name, date of service, amount charged for service and diagnosis.** Expenses may be submitted by having your doctor complete an Attending Physician's Statement, which your doctor will provide. Do not submit photocopies, cash register receipts or cancelled checks. Make copies of all claims before they are submitted. Claim personnel cannot provide copies.

4. **If HealthSCOPE Benefits is not the primary carrier for this claim, submit an original Explanation of Benefits (EOB) from the primary payor and copies of the bills.** Claims cannot be processed without the other plan's EOB.

5. **Payments are made to you unless indicated on the claim form**. If you want benefits paid directly to a provider, please select "Yes" where prompted on the claim form.

6. **Sign and date the front side of this form (bottom left hand side), indicating the information provided is correct and authorizing release of information necessary to process this claim.**

7. **Submit claims with this claim form to:**

The address listed on your ID Card