



Claim Form for Medical Benefits

TO BE COMPLETED BY THE EMPLOYEE

1. Employee's Name _____ Date of Birth _____
First Middle Last

2. Employer's Name _____ Group Number _____

3. Employee's Home Address _____ Yes No
Is this a new address?

4. Employee's City _____ State _____ Zip _____

5. Employee's Social Security # _____ - _____ - _____ Telephone No. (_____) _____ - _____

6. Are any of your dependents including your spouse presently employed? Yes No

Name	Social Security Number	Relationship	Name/Address of Employer (Including Zip Code and Phone No.)

7. Are any medical, dental or pharmacy expenses covered under another employer group, union, welfare plan school, or program? No Yes - if "Yes", complete the following:

Name and address of company or organization (i.e., employer, union, association, etc...) sponsoring the plan or program

Name and address of insurance carrier _____

Policy Number _____

8. If any of the expenses included on the claim are covered under Medicare, complete the following:

Is the patient covered under MEDICARE Hospital insurance Part A YES NO Eff. Date ____/Mo.____/Day ____/Year
Is the patient covered under MEIDCARE Hospital insurance Part B YES NO Eff. Date ____/Mo.____/Day ____/Year

9. If expenses on this claim are for medical services for an eligible dependent, answer the following:

Dependent's Name _____
First Middle Last

Date of Birth Mo. ____/Day ____/Year _____ Sex: Male Female

Relationship to Employee: Spouse Child under 19 Child 19 or over

If Dependent Child is 19 or over, answer the following:

Full Time Student Name of School _____

Employed Full Time Employed Part Time Unemployed Disabled

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any physician, hospital, pharmacy, insurance company, employer, third party payer or organization to release any information regarding the history, treatment, or benefits payable concerning this claim to SummaCare or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim.

I certify that the information submitted by me is true and correct and I understand that falsifying a claim can lead to disciplinary action, including discharge.

Employee's Signature _____ Date _____

Any Person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits fraudulent insurance act which is a crime.

INSTRUCTIONS FOR FILING A CLAIM

Complete the employee's section on the reverse side.

Send completed claim form and itemized bills to:

- Use a separate claim form for EACH member of the family for each claim submitted
- Complete the Authorization Section above
- All bills for related expenses should be submitted at the same time.

SummaCare
P.O. Box 3620
Akron, Ohio 44309-3620
(330) 996-8515
(800) 753-8429

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER

Signature _____

Diagnosis or nature of illness or injury – related diagnosis to procedure in column D by reference to numbers 1, 2, 3 etc or diagnosis code.

- 1.
- 2.
- 3.
- 4.

Date of Service	*Place of Service	Procedures, medical services or supplies furnished for each date given	ICD – 9 Diagnosis	Charges
		CPT-4 Procedure Code Identity Explain unusual Services or circumstances		\$
				\$
				\$
				\$
				\$
TOTAL CHARGES				\$

Place of Service Codes

11	Doctor or Providers Office	12	Patient Home	21	Inpatient Hospital	22	Outpatient Hospital
23	Emergency Room	24	Ambulatory Surgery Center	41	Ambulance	81	Laboratory
C3	Urgent Care Center	99	Other Location				

Signature of Physician/Provider _____

Physician/Provider Name _____

Provider Address _____

Provider City _____ State _____ Zip _____

Physician/Provider Tax ID Number _____ Phone _____

Patient's Acct No. _____