Medical Claim Form

MAIL COMPLETED CLAIM FORM TO:
HealthChoice
P. O. Box 99011
Lubbock, TX 79490-9011

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 # (found 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)	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? ☐ Yes ☐ No If so, has a Workers' Compensation claim been filed? ☐ 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 HealthChoice, 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 HealthChoice 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 HealthChoice 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 family member's name that matches the claim you are submitting.
2. Complete all sections of the claim form.
3. All bills must include the patient's name, date of service, billed charge, and diagnosis. Charges may be submitted by having your doctor complete an Attending Physician's Statement which your doctor will provide. Do not submit copies, cash register receipts or cancelled checks. Make copies of all claims before mailing. The claims office cannot make copies for you.
4. If HealthChoice is not the primary carrier for this claim, submit an original Explanation of Benefits (EOB) from the primary payer and copies of the bills. Claims cannot be processed without the other plan's EOB.
5. Payments are made to you unless you tell us otherwise on the claim form. If you want benefits paid directly to a provider, please select "Yes" where asked on the claim form.
6. Sign and date the bottom of the claim form. By signing, you are confirming that the information provided is correct. You are also authorizing release of information necessary to process your claim.
7. Submit claims with the completed claim form to the address listed on your ID card.

CLEAN CLAIM

A "clean claim" means a completed UB04 form or HCFA 1500 form. If the provider doesn't complete one of these forms, a clean claim should include the following:

- The provider's name and tax ID number;
- The date of service;
- The procedure and diagnosis codes with the provider's billed charge;
- The name of the employer;
- The policy number or group number on the ID card;
- The employee's name, home address, and ID number on the ID card;
- The patient's date of birth.

A clean claim does not include a claim with missing information, or claims for coordination of benefits or subrogation.

TIMELY FILING

Timely Filing Limits can be found in your SPD under the section titled "When Health Claims Must Be Filed" or you can contact the Customer Care team at the number listed on your ID card for assistance in determining your plan's timely filing requirement. The SPD and the Customer Care team number can also be found on the website at www.healthchoiceconnect.com.