Statement of Claims Form

Medica

For medical claims, please complete this form and the Health Insurance Claim Form found on page 3. If you have questions, please contact Medica Customer Service at **(952) 945-8000** or toll-free outside the Twin Cities metro area at **1 (800) 952-3455** (TTY: **711**).

Throughout this form, all self-insured enrollees will be referred to as "members" rather than their formal title of "self-insured enrollees."

Note: For pharmacy claims, please use the Prescription Claim Form, available at Medica.com/MemberForms. For foreign claims, please contact Customer Service at the phone number on the back of your ID card for special instructions.

Please ensure that this entire claim form has been properly completed and signed prior to submitting to Medica. Payment will be made to you, unless you sign #13 on the Health Insurance Claim Form, or specifically direct otherwise.

Mail these forms and/or itemized bills to:
Medica
P.O. Box 30990
Salt Lake City, UT 84130

A MEMBER INFORMATION

Member's Name:	Employer's Name:
Member ID Number:	Group/Policy Number:

Residence Address

Street: City: State: ZIP Code:

B PATIENT INFORMATION

Patient's Name:	Patient's Date of Birth:
Describe Illness or Injury:	Date it Began:

Check appropriate circle below if claim was due to one of the following:
❍ Auto accident ❍ Dental injury ❍ Emergency ❍ Mental health or substance abuse

If injury, was it job related? ❍ Yes ❍ No
If Yes, please explain:

Do you or does any member of your immediate family have any other group insurance which may cover all or part of this claim?
❍ Yes ❍ No
If Yes, give insurance company name, address and group/policy number:

A person who submits an application or files a claim with intent to defraud or helps commit fraud against an insurer is guilty of a crime.

Authorization: On behalf of myself and any patient named on this claim form ("Us"), I authorize any health care professional or entity, employer, union, insurance company, health maintenance organization, other health plan company or prepayment organization to give Medica Health Plans, Medica Insurance Company, Medica Health Plans of Wisconsin, or Medica Self-Insured and my employer, or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for evaluation of this claim, and for any analytical or research purposes. This authorization will automatically expire one year following the date of signature without my express revocation.

Member's Signature:	Date:

Health Insurance Claim Form

Instructions

The following fields must be completed on the Health Insurance Claim Form in order for your claim to be processed:

1. Check the "Group Health Plan" box
1a. Insured's I.D. Number
2. Patient's Name
3. Patient's Birth Date and Sex
4. Insured's Name
5. Patient's Address
6. Patient Relationship to Insured
10. Is Patient's Condition Related To
11. Insured's Policy, Group or FECA Number
12. Patient's or Authorized Person's Signature
24.A Date(s) of Service
24.B Place of Service Code

If you are unsure what the Place of Service Code for your situation is, please see some of the most common codes below. If none of the codes listed apply to you, you may need to ask your provider for the information needed to complete this field.

11. Office: Location where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury.

20. Urgent Care Facility: Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21. Inpatient Hospital: A facility, other than psychiatric, which primarily provides care, and rehabilitation services by, or under, the supervision of physicians to patients admitted for greater than 24 hours.

22. Outpatient Hospital: A facility, other than psychiatric, which primarily provides care, and rehabilitation services by, or under, the supervision of physicians to patients admitted for less than 24 hours.

23. Emergency Room – Hospital: A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24.C Type of Service*
24.D Procedures, Services, or Supplies*
24.E Diagnosis Code*
24.F Charges
25. Federal Tax I.D. Number*
28. Total Charge
33. Physician's or Supplier's Billing Name, Address, ZIP Code and Telephone Number

*You will need to ask your provider for the information to complete this field.

Please also include copies of any bills, receipts or itemized statements from all providers. Please make sure your 5 or 6 digit Group or Policy number and your 9 digit ID number are listed on all pages of correspondence that are submitted. Make copies of all correspondence (keep one copy for your own records) and send a legible copy of all documents, including the completed claim forms, to:

Medica
P.O. Box 30990
Salt Lake City, UT 84130

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)