

Statement of Claim for Members and Dependents

INSTRUCTIONS

- For routine optical, orthodontia or hearing aid benefits claimed, have attending physician complete the appropriate section on reverse side and/or attach itemized bills.
- For prescription expense balances only after primary insurance carrier payment, please attached itemized pharmacy receipts and other carrier payment information. Submit all other prescription expenses to MEDCO for reimbursement.
- A separate form should be submitted for each provider of service.
- This form may be used to update any of the below information.
- Claimant's statement must be completed in full, signed and dated by member, spouse or responsible guardian.
- Benefits payable may be assigned providing proper authorization is completed on reverse side or submitted with statement. Checks will then be mailed directly to the provider of service indicated.

MEMBER INFORMATION					
Member's Name (Last, First, Middle Initial)		Date of Birth		SSN	
Martial Status (Check One) Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/>					
Mailing Address Check box if NEW address <input type="checkbox"/>		Street	City	State	Zip Telephone Number
Member Status (Check One)		Last Employment: Company			
Sailing <input type="checkbox"/>		Vessel			
Port Engineer <input type="checkbox"/>		From			
Pensioner <input type="checkbox"/>		Through			
Cobra <input type="checkbox"/>					
Other (Specify) <input type="checkbox"/> _____					
PATIENT INFORMATION (COMPLETE ONLY IF PATIENT IS OTHER THAN MEMBER)					
Patient's Name (Last, First, Middle Initial)		Date of Birth		Gender Male <input type="checkbox"/> Female <input type="checkbox"/> SSN	
Relationship to Member			Is Dependent Employed? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Step Daughter <input type="checkbox"/> Step Son <input type="checkbox"/>			Name of Employer:		
Parent <input type="checkbox"/> Other <input type="checkbox"/> _____					
Patient Address (if different from above)			If other than your spouse, is your dependent:		
Street			Married? Yes <input type="checkbox"/> No <input type="checkbox"/>		
City, State, Zip			A Full-Time Student? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Telephone Number					
OTHER COVERAGE INFORMATION					
Are you or your dependent(s) covered by any other insurance providing health care benefits? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete the following:					
Name of Policyholder/Subscriber		Relationship to Patient		ID Number Group Number	
Is this coverage: Group? <input type="checkbox"/> Individual? <input type="checkbox"/> Does this coverage included dependents? Yes <input type="checkbox"/> No <input type="checkbox"/>			Is coverage through: Active Employment? <input type="checkbox"/> Retirement? <input type="checkbox"/> Employer Name: _____		
Effective Date of Coverage: _____					
Name of Other Insurance Plan: _____					
Does coverage include? Medical <input type="checkbox"/> Prescriptions <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/>					
Is Patient Eligible for Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please complete following Medicare Eligible by virtue of: Age 65 and over <input type="checkbox"/> End State Renal Disease <input type="checkbox"/> Federal Social Security Disability <input type="checkbox"/> (copy of FSSD Award is required for our records)					
Medicare Effective Date : _____					
"I hereby certify that all the above statements are true and complete according to the best of my knowledge and belief. I authorize any insurer, hospital, practitioner or other person(s) to disclose any information regarding my (or my dependent's) insurance coverage of medical history."					
Date: _____			Signature: _____ (If other than member, indicate relationship)		

Patient's Name: _____ Patient's Date of Birth: _____

I hereby authorize payment of benefits directly to the provider of services indicated below:

Date: _____ Signature: _____

PLEASE HAVE PROVIDER COMPLETE BELOW OR ATTACH ITEMIZED BILL THAT INCLUDES ALL REQUIRED INFORMATION

OPTICAL BENEFIT

TO BE COMPLETED BY OPHTHALMOLOGIST, OPTOMETRIST OR SUPPLIER

Diagnosis (ICD9): _____ Eye Examinations _____ Prescription Lenses and Frames _____
 Date of Exam: _____ Date of Purchase: _____

Services/Description	CPT/HCPCS Code	Charges	Services/Description	CPT/HCPCS Code	Charges
Exam			Lenses		
Determination of Refractive State			Frame		
Other:			Other:		
			Contact Lenses		
			Other:		

ORTHODONTIA BENEFIT

TO BE COMPLETED BY ORTHODONTIST OR DENTIST

Date appliance placed: _____ Total treatment fee: _____ Down payment fee: _____

Estimated months of treatment: _____ Total# of monthly payments: _____ Monthly maintenance fee: _____

Date of Service	Tooth Number	Procedure Code	Description	Charges

HEARING AID BENEFIT

TO BE COMPLETED BY PHYSICIAN, AUDIOLOGIST OR OTHER LICENSED PRACTITIONER

In my professional opinion a hearing aid is () , is not () required.

Services/Description	Procedure Code (CPT/HCPCS)	Date of Service	Charges
Examination Fee			
Other:			
Hearing Instrument			
Other:			

PROVIDER OF SERVICE

I hereby certify that the services listed above are correct and represent those rendered to the patient named.

Physician/Practitioner's Name and Title (Print)

Telephone No.

Street Address

City

State

Zip Code

Date

Physician/Practitioner's Signature

Make check payable to:

Social Security Number or

Employer Identification Number

NPI Number

License Number

Provider Specialty Code

X

X