

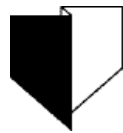
Health Claim Form



Complete and send to:
 Meritain Health
 P.O. Box 27267
 Minneapolis, MN 55427-0267
Fax: 952-593-3727

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

1. EMPLOYEE INFORMATION					
Name (last, first, initial)		Sex	Employer Name		
Home Address		Identification Number	Birthdate	Group Number	
City	State	ZIP Code	Work Telephone ()	Home Telephone ()	
2. PATIENT INFORMATION					
The Patient is: <input type="checkbox"/> THE EMPLOYEE (go to No. 3) <input type="checkbox"/> EMPLOYEE'S SPOUSE (complete spouse information) <input type="checkbox"/> EMPLOYEE'S CHILD (complete spouse and child information)					
Spouse's Name (last, first, initial)		Sex	Child's Name (last, first, initial)		Sex
Spouse's Birthdate	Spouse's Social Security Number		Child's Birthdate	Child's Social Security Number	
Spouse's Employer			If child is over age 19 and full-time student, complete: Name of School:		
Spouse's Employer's Address			School Address		
3. OTHER COVERAGE					
<input type="checkbox"/> YES (then complete)		<input type="checkbox"/> NO (go to No. 4)		NAME OF POLICYHOLDER:	
Name of Other Health Insurance Carrier or Plan		Address		City	State ZIP Code
Other Insurance Carrier's or Plan's Telephone No.		Type of Coverage <input type="checkbox"/> GROUP <input type="checkbox"/> INDIVIDUAL		Group Number	Contract or Policy Number
Spouse's Employer			If child is over age 19 and full-time student, complete: Name of School:		
Spouse's Employer's Address			School Address		
4. ABOUT THIS CLAIM					
<input type="checkbox"/> INJURY <input type="checkbox"/> ILLNESS		Describe injury, when and how it happened or nature of illness:			
Date and time of accident:					
Was injury the result of auto accident? If auto insurance involved, please provide:		<input type="checkbox"/> YES Policy No	<input type="checkbox"/> NO Name of Insurance Company	Address (City, State, ZIP Code)	
Work related injury? <input type="checkbox"/> YES <input type="checkbox"/> NO		If injury is work related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.			
<input type="checkbox"/> WELL CHILD CARE <input type="checkbox"/> ROUTINE PHYSICAL EXAM		If illness, date of first treatment: If pregnancy, expected delivery date:			
5. EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED					
The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.					
Signature _____			Date _____		
6. ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)					
I authorize payment of benefits directly to the doctor or supplier of services listed here.					
Provider to be paid _____		Employee's Signature _____			
Provider's Tax ID No. or Social Security No. _____		Date _____			



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PHYSICIAN OR SUPPLIER STATEMENT

A	Patient Name (last, first, middle initial)	Birthdate				
B	Address					
C	Is condition the result of an injury arising from patient's employment? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please contact the Workers' Compensation Carrier/Administrator for proper instruction regarding this claim.</i>					
D	Pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, expected date of delivery				
E	If illness, date of first treatment	If treating injury, date of injury				
F	Name of referring physician	Referring physician's address				
G	Name and facility where services were rendered (if other than home or office)					
H	Was laboratory work performed outside your office? <input type="checkbox"/> YES <input type="checkbox"/> NO					
I	For service related to hospitalization, give dates: <input type="checkbox"/> ADMITTED _____ <input type="checkbox"/> DISCHARGED _____					
J	Diagnosis and current conditions (if diagnosis other than ICD-9* used, give name): 1. 2. 3. 4.					
K	Dates of Service From To	Places of Services†	Procedure Code (If other than CPT** code used, give name)	Description of surgical or medical services rendered	Diagnosis Code	Charges
* ICD-9 International Classification of Disease		† ABBREVIATIONS:		11 - Physician's Office	21 - Inpatient Hospital	23 - Emergency Room
** CPT Current Procedural Terminology (current edition)				12 - Patient's Home	22 - Outpatient Hospital	81 - Independent Laboratory
Date		Physician's Name (print)		Degree		Provider's Tax ID No. or Social Security No. <input style="width:100px; height:20px;" type="text"/>
Physician's Signature _____ Telephone ()				Must be furnished under authority of law		
Street Address			City		State	ZIP Code

STATUS AND BENEFIT INFORMATION:
1-800-925-2272



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