Health Claim Form

MERITAIN HEALTH
An Aetna Company

Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057
Email: SCPMG.Claims@meritain.com

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.

Section 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 ( )	

Section 2. PATIENT INFORMATION

The patient is: ☐ **The employee** (Go to section 3) ☐ **Employee's Spouse** (Complete spouse information) ☐ **Employee's Child** (Complete spouse and child information)

Spouse's Name (last, first, initial)	Sex	Child's Name (first, last, initial)	Sex
Spouse's Birthdate	Spouse's Social Security Number	Child's Birthdate	Child's Social Security Number
Spouse's Employer			
Spouse's Employer's Address			

Section 3. OTHER COVERAGE

☐ **Yes** (then complete) ☐ **No** (go to section 4) **Name of Policy Holder:**

Name of Other Health Insurance Carrier or Plan	Address	City	State	Zip Code
Other Insurance Carrier's or Plan's Telephone #	Type of Coverage ☐ **Group** ☐ **Individual**	Group Number	Contract or Policy Number	
Spouse's Employer				
Spouse's Employer's Address				

Section 4. ABOUT THIS CLAIM

☐ **Injury** ☐ **Illness**
Date and time of accident:

Describe injury, when and how it happened or nature of illness:

Was this injury the result of an accident? ☐ **Yes** ☐ **No**

If auto insurance was involved, please provide:	**Policy #**	**Name of insurance company**	**Address (city, state, zip)**

Was this a work-related injury? ☐ **Yes** ☐ **No**

If injury is work-related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.

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 photo-static 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:**

ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)

I authorize payment of benefits to the doctor or supplier of services listed here.

Provider to be paid	Employee's Signature
Provider's tax ID number or Social Security Number	Date

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A	**Patient Name (last, first, initial)**	**Birthdate**
B	**Address**	
C	**Is this condition the result of an injury arising from patient's employment?** ☐ **Yes** ☐ **No** ***If yes, please contact the Worker's Compensation Carrier/Administrator for proper instruction regarding this claim.***	
D	**Pregnancy?** ☐ **Yes** ☐ **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?** ☐ **Yes** ☐ **No**	
I	**For service related to hospitalization, give dates:** ☐ **Admitted** ☐ **Discharged**	
J	**Diagnosis and current conditions (if diagnosis other than ICD-10* 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-10 *** International Classification of Disease ****Abbreviations:** 11-Physician's Office 12-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 Number or Social Security Number:
			Must be furnished under authority of law

Physician's Signature	Telephone
	( )

Street Address	City	State	Zip Code

STATUS AND BENEFIT INFORMATION:
1.888.711.7876

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