The HealthPlan

1110 Main Street
Wheeling, WV 26003-2704
P: 1.800.624.6961
healthplan.org

Member Submitted Claim Form

This form is to be used for medical, vision, and dental claims where you incurred expenses from a provider who did not bill the plan directly. **Do not use this form for prescription reimbursement.** Please use the Prescription Drug Reimbursement Form. See instructions on other side for additional information to complete your claim.

Section 1: Patient/Member

ID number/suffix	Group number	Patient name (first, middle, last)	
Address	City	State	ZIP code
Home phone	Work or alternate phone	Employee name	Email address

Does the patient have coverage from any other health plan?

☐ No, skip to Section 2 ☐ Yes, please attach the explanation of benefits (EOB) statement from the primary plan with this claim and complete following information:

Name of other health plan	ID number or policy number of other health plan	Phone number of other health plan

Section 2: Claim Details

NOTE: You must submit an itemized bill or your claim will be returned.

Have the charges been paid in full? ☐ No ☐ Yes, please attach proof of payment in full with your itemized bill.

In what setting were these services performed? ☐ Inpatient hospital ☐ Outpatient hospital ☐ Office/Clinic ☐ Surgery center ☐ Skilled nursing facility ☐ Home ☐ Other

Section 3: International Claim

NOTE: You must submit an itemized bill or your claim will be returned.

Is this claim for expenses incurred outside of the United States?

☐ No, skip to Section 4 ☐ Yes, please attach an itemized bill, available medical records and complete this section (itemized bill and medical records must be in English):

Name of Provider	Type of Provider ☐ Hospital ☐ Lab ☐ Office ☐ X-ray	Country of service	City of service	Date of service
Diagnosis (describe illness and symptoms requiring treatment)			Charges	Currency used

Does the patient have coverage from any other health plan?

☐ No, skip to Section 2 ☐ Yes, please attach the explanation of benefits (EOB) statement from the primary plan with this claim and complete following information:

Section 4: Accident/Injury

Is this claim due to an accidental injury? ☐ No, skip to Section 5 ☐ Yes, complete this section:	Date of accident	Where did the accident occur? ☐ Home ☐ Work ☐ School ☐ Auto ☐ Other

How did the accident happen?

Description of injury:

Section 5: Signature

To be accepted, this form must be fully completed (as appropriate to the claim being submitted), signed and have and itemized bill attached.

Mail to: The Health Plan, ATTN: Operations Support Unit, 52160 National Road E., St Clairsville, OH 43950-9365

Patient signature (or legal guardian if patient cannot legally consent to services)	Relationship to patient ☐ Self ☐ Other	Date (mm/dd/yyyy)

Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Instructions

A. **Complete a claim form.** Most providers will bill directly for you and no claim form will be necessary. However, if you do incur expenses from a provider who will not bill the plan directly, you will need to complete a claim form and provide an itemized bill. (See section B for information about itemized bills.)

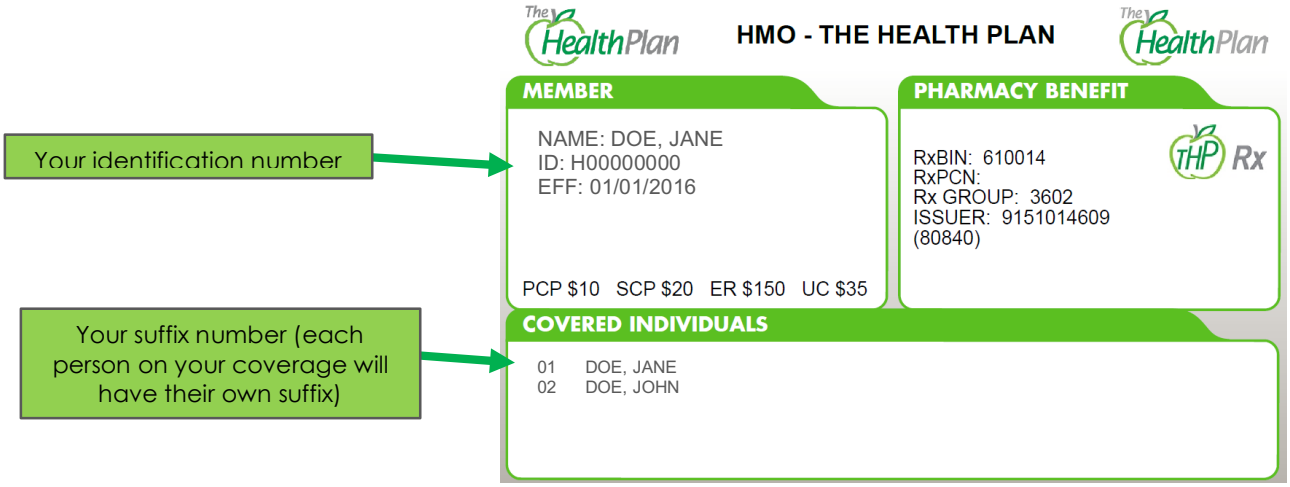
B. **Attach the itemized bill.** Please do not highlight or modify the itemized bill as this may cause delayed processing of your claim.

The itemized bill must contain all of the following information:

a. Name of the member who incurred the expense.
b. Name, address, and IRS tax identification number of the provider.
c. Diagnosis code (ICD-10). This information must be obtained from your provider.
d. Procedure codes (CPT-4, HCPCS, ADA, or UB-04). This information must be obtained from your provider.
e. Date of service and itemized charge for each service rendered.

Please note: Your claim will be returned if all of the required information listed above is not included.

C. **The front of your member ID card may not match the card pictured below.** This sample card is meant to be a guide to help you identify your suffix and identification number.



D. **The back of your member ID card provides additional information.** To help ensure your claims are paid properly, encourage physicians and other providers to copy the front and back of your card each time you visit.

You can research claim and eligibility information online. Visit our website at www.healthplan.org. You may also call Customer Service at the phone number shown on the back of your ID card.