

Health Benefits Claim Form

Please mail completed form to:

HealthSmart Benefit Solutions ■ P.O. Box 91608 ■ Lubbock, TX 79490

Patient's Information

Claim Is Made For <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Self <input type="checkbox"/> Unmarried Son/Daughter <input type="checkbox"/> Other	Patient's Name (First, Initial, Last)	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Full-Time Student Attending (School Name)	Expected Date of Graduation		

If Injury Is Due To An Accident

Date of Accident	Place of Accident	Briefly Describe Accident
Was patient at work when accident occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was the accident due to someone's negligence? <input type="checkbox"/> Yes <input type="checkbox"/> No

Other Insurance/Medicare

Any other medical benefits for employee, spouse, or patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
If Dependent or Spouse, Full Name	Date of Birth
Coverage Paid Through <input type="checkbox"/> Medicare <input type="checkbox"/> Employer Sponsored Plan <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Policy <input type="checkbox"/> Other <input type="checkbox"/> CHAMPUS	Last Day of Effective Coverage
Effective Date of Coverage	Phone Number of Other Insurance Company
Name of Other Insurance Company	

Please attach other insurance explanation of benefits, if applicable.

Employee's Information

Name (First, Initial, Last)	Social Security Number	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address	City	State	ZIP
Employer's Name	Employer's Telephone Number	Group Number	
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA <input type="checkbox"/> Laid Off	Date Laid Off	Marital Status	
Patient's or Authorized Person's Signature I authorize the release of any medical information necessary to process this claim.	Authorization for Payment of Medical Benefits I hereby authorize payment of medical benefits to physicians or suppliers for services billed on this claim.		
Signature	Date	Signature (Insured or Authorized Person)	
Employee's Signature	Date		

I hereby certify the above information is true and correct.

Please do not staple in this area

Health Insurance Claim Form

<input type="checkbox"/> Medicare <small>(Medicare #)</small>	<input type="checkbox"/> Medicaid <small>(Medicaid #)</small>	<input type="checkbox"/> CHAMPUS <small>(Sponsor's SSN)</small>	<input type="checkbox"/> CHAMPVA <small>(VA File #)</small>	<input type="checkbox"/> Group Health Plan <small>(SSN or ID)</small>	<input type="checkbox"/> FECA <small>(SSN)</small>	<input type="checkbox"/> Other <small>(ID)</small>	Insured's ID Number
Patient's Name (Last, First, Initial)				Patient's Date of Birth (MM/DD/YY)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Insured's Name (Last, First, Initial)
Patient's Address			Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Insured's Address	
City	State		Patient's Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/> Employed Part-Time			City	State
ZIP	Telephone					ZIP	Telephone
Other Insured's Name (Last, First, Initial)			Is patient's condition related to employment? (Current or Previous) <input type="checkbox"/> Yes <input type="checkbox"/> No			Insured's Policy Group or FECA Number	
Other Insured's Policy or Group Number			Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Location	State	Insured's Date of Birth (MM/DD/YY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Other Insured's Date of Birth (MM/DD/YY)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Other Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			Employer or School Name	
Employer or School Name			Reserved for Local Use			Insurance Plan or Program Name	
Insurance Plan or Program Name			Reserved for Local Use			Reserved for Local Use	

Read front of form before completing and signing this form.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to me or to the party who accepts assignment below.

I authorize payment of medical benefits to undersigned physician or supplier for services described below.

Signature	Date	Signature
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Date of Current Illness (First Symptom), Injury (Accident), Pregnancy (LMP) (MM/DD/YY)	If Patient Same or Similar Illness (MM/DD/YY)	Date Patient Unable to Work in Current Occupation
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Name of Referring Physician or Other Source	ID Number of Referring Physician	Hospitalization Dates Related to Current Services (MM/DD/YY) to (MM/DD/YY)
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Reprinter ID/Reprinter Name	Outside Lab? <input type="checkbox"/> Yes <input type="checkbox"/> No	Charges \$
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Diagnosis or Nature of Illness or Injury 1 2	Medicaid Resubmission Code	Original Reference Number
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Diagnosis or Nature of Illness or Injury 3 4	Prior Authorization Number
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Date of Service From (MM/DD/YY)	Date of Service To (MM/DD/YY)	Place of Service	Type of Service	Procedures, Services, or Supplies (Explain unusual circumstances) CPT HCPCS Modifier	Diagnosis Code	Charges	Days or Units	EPSDT Family Plan	Repricing Method Code	Repriced Rejection Code	Repriced Amount

Federal Tax ID Number <input type="checkbox"/> SSN <input type="checkbox"/> EIN	Patient's Account Number	Accept Assignment <input type="checkbox"/> Yes <input type="checkbox"/> No	Total Charge \$	Amount Paid \$	Balance Due \$
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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.)

Service Facility Location Information	Billing Provider Information	Phone Number
NPI	NPI	

Please Print or Type