PIEDMONT COMMUNITY HEALTH PLAN / PIEDMONT COMMUNITY HEALTHCARE

HEALTH BENEFITS CLAIM FORM

Please submit your billing along with this claim form to:
P.O. Box 14408
Cincinnati, OH 45250-0408

Address Change:_____

IMPORTANT: EVERY ITEM MUST BE CHECKED OR ANSWERED BEFORE CLAIM CAN BE PROCESSED

PATIENT

GIVE THE FOLLOWING INFORMATION ABOUT PATIENT

1. Claim is made for:	2. Patient's Name	3. Date of Birth	4. Sex
❒ Husband ❒ Self ❒ Wife ❒ Unmarried ❒ Other _____ Son/Daughter			❒ M ❒ F

5. Full Time Student
Attending _____

Expected Date of Graduation _____

IF DUE TO AN ACCIDENT, ANSWER ITEMS 6-10	6. Date of Accident	7. Place of Accident	8. Was Patient at Work When Accident Occurred? ❒ Yes ❒ No
	9. Briefly Describe Accident		10. Was the accident Due to Someone's Negligence? ❒ Yes ❒ No

GIVE THE FOLLOWING INFORMATION ABOUT OTHER INSURANCE/MEDICARE

EMPLOYEE

11. Any other Medical benefits for employee, spouse, or patient? ❒ Yes ❒ No
If yes, who? ❒ Self ❒ Spouse ❒ Dependent
If Dependent or Spouse, Full Name _____ Date of Birth _____

Coverage Paid Through ❒ Medicare ❒ Medicaid ❒ Other ❒ Employer Sponsored Plan ❒ Private Policy ❒ Champus
Effective Date of Coverage _____
Last Day of Effective Coverage _____

Give Name of Other Insurance Company _____

Phone Number of Other Insurance Company _____

Please Attach Other Insurance Explanation Of Benefits If Applicable

GIVE THE FOLLOWING INFORMATION ABOUT YOURSELF

12. Name (First) (Middle Int.) (Last)	13. Social Security Number	14. Date of Birth 15. Sex ❒ M ❒ F

16. Home Address (Number) (Street) (City) (State) (Zip Code)

17. Employer Name	18. Company Number	19. Employment Status ❒ Active ❒ Cobra	20. Marital Status ❒ Single ❒ Widowed ❒ Married ❒ Legally Separated ❒ Divorced

21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any Medical Information Necessary to Process this Claim.

_____
SIGNED DATE

22. AUTHORIZE FOR PAYMENT OF MEDICAL BENEFITS
I herby authorize payment of medical benefits to physician's or supplier's for services billed on this claim.

_____
SIGNED (Insured or Authorized Person)

23. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

Employee's Signature _____ Date _____

HEALTH BENEFITS CLAIM FORM

TO BE COMPLETED BY PHYSICIAN
(Not required if itemized billing attached)

TYPE OR PRINT

PHYSICIAN SUPPLIER INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*

2. PATIENT'S DATE OF BIRTH

3. EMPLOYEE'S NAME *(First name, middle initial, last name)*

4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*

5. PATIENT'S SEX
MALE ❒ FEMALE ❒

6. EMPLOYEE'S SOCIAL SECURITY NUMBER

7. PATIENT'S RELATIONSHIP TO EMPLOYEE

SELF	SPOUSE	CHILD	OTHER

8. EMPLOYER AND POLICY NUMBER

9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number.

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT?
YES [ ] NO
B. AN AUTO ACCIDENT?
YES [ ] NO

11. INSURED'S ADDRESS (*Street, city, state, ZIP code*)

12. DATE OF ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

13. DATE FIRST CONSULTED YOU FOR THIS CONDITION

14. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?
YES [ ] NO

15. DATE PATIENT ABLE TO RETURN TO WORK

16. DATE OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

17. NAME OF REFERRING PHYSICIAN

18. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

19. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*

20. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES [ ] NO CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.

2.

3.

4.

22. A. DATE OF SERVICE	B.* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D. DIAGNOSIS CODE	E. CHARGES	F.

23. TOTAL CHARGE

24. TOTAL PAID

25. BALANCE DUE

26. SIGNATURE OF PHYSICIAN OR SUPPLIER
SIGNED DATE

27. ACCEPT ASSIGNMENT
(Government Claims only)
YES [ ] NO

30. PHYSICIAN'S SOCIAL SECURITY NO.

28. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.

29. YOUR PATIENT'S ACCOUNT NO.

YOUR EMPLOYER
I.D. NO. _____

*PLACE OF SERVICE CODES – THIS NUMBER IS REQUIRED TO BE FURNISHED UNDER AUTHORITY OF LAW

1 - (H) - INPATIENT HOSPITAL
2 - (OH) - OUTPATIENT HOSPITAL
3 - (O) - DOCTOR'S OFFICE
4 - (H) PATIENT'S HOME
5- DAY CARE FACILITY (PSY)
6- HOME CARE FACILITY (PSY)
7 - (NH) - NURSING HOME
8 - (SNF) SKILLED NURSING FACILITY
9 - AMBULANCE
O - (OL) - OTHER LOCATIONS
A - (IL) INDEPENDENT LABORATORY
B - OTHER MEDICAL/SURGICAL FACILITY