



MEDICAL CLAIM FORM

GROUP NAME _____ GROUP # _____

HOW TO PRESENT A CLAIM

1. Complete the "Employee Information" below. A separate form will be required for each family member. To avoid delay be sure to answer all questions.
2. Have the **doctor** complete the **reverse** side of this form or attach itemized billing from your doctor. If you have more than one doctor, the information should be provided by the physician who rendered the most service, or in the case of surgery, by the primary surgeon.
3. Bills submitted for each person must show (a) name of the patient, (b) type of service rendered, (c) date of service rendered and (d) the amount of the charge. Bills and receipts for drugs and medicine must show the (a) name of the patient (b) prescribing physician (c) prescription number or nature of medication, (d) date of purchase and (e) charge for each prescription.

WHERE TO SEND A CLAIM

Hometown Health Providers Insurance Co.
10315 Professional Circle
Reno, NV 89521

PHONE CLAIM INQUIRIES
775-982-3232
1-800-336-0123

EMPLOYEE INFORMATION

EMPLOYEE'S NAME			SEX: M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL STATUS	MEMBER ID NO.		
Last	First	Middle		<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated			
EMPLOYEE'S ADDRESS					DATE OF BIRTH		
Number and Street	City	State	Zip Code	Month	Day	Year	
SECTION 1. a. Is your spouse employed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If the answer to either is "Yes," please show in "Remarks" the names of the persons who are employed, and the name and address of their respective employers.</i>				
b. If claim is for any child, is that child employed?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
SECTION 2.				SECTION 3.			
a. Other Group Health insurance/coverage of any kind?				<input type="checkbox"/> Yes <input type="checkbox"/> No	Was illness or injury due, in any way:		
b. Group prepayment arrangement providing for medical care and treatment?				<input type="checkbox"/> Yes <input type="checkbox"/> No	a. To the patient's occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency?				<input type="checkbox"/> Yes <input type="checkbox"/> No	b. To an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
d. No fault automobile insurance as a result of injuries sustained in an automobile accident?				<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Any other type of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If any of the above are answered "yes," please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or governmental agency.</i>							
REMARKS: Please indicate which question you are answering by giving Section and Question number, such as 2a. (If additional space is needed, attach separate page).							

DEPENDENT INFORMATION Complete only if patient is a dependent.

DEPENDENT'S NAME			SEX: M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL STATUS	DATE OF BIRTH		
Last	First	Middle		<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated	Month	Day	Year
RELATIONSHIP				DATE OF BIRTH			MEMBER ID NO.
<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				Month Day Year			
IF CLAIM IS FOR DEPENDENT CHILD PLEASE INDICATE SPOUSE'S DATE OF BIRTH AND MEMBER ID NO.							
IF CLAIM IS FOR DEPENDENT CHILD 19 OR OLDER							
Is child enrolled as full time student? <input type="checkbox"/> Yes <input type="checkbox"/> No				If Yes, give name of school			

The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization to release to each other, any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A photostat of this authorization shall be as valid as the original.

Employee's Signature _____ Date _____ Patient's Signature (Parent, if patient is a minor) _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of benefits directly to the Physician signing the reverse side of this form. SIGNED (COVERED ENROLLEE) _____ DATE _____



MEDICAL CLAIM FORM

- GROUP
 MEDICARE

THIS FORM SHOULD BE COMPLETED AS SOON AS POSSIBLE AND RETURNED TO THE EMPLOYEE OR DIRECTLY TO: Hometown Health Providers Insurance Co.
10315 Professional Circle
Reno, NV 89521

TYPE OR PRINT

PATIENT & EMPLOYEE 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)			
PHYSICIAN OR SUPPLIER INFORMATION							
14. DATE OF SERVICE		ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15. DATE FIRST CONSULTED YOU FOR THIS CONDITION		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____			
19. NAME OF REFERRING PHYSICIAN				20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____			
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)				22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES			
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE 1 2 3 4							
24. A	B	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D	E	HHPIC USE ONLY	
DATE OF SERVICE	PLACE OF SERVICE	PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	DIAGNOSIS CODE	CHARGES	PRE-CERTIFICATION	
						REQUIRED?	OBTAINED?
25. SIGNATURE OF PHYSICIAN OR SUPPLIER				27. TOTAL CHARGE		28. AMOUNT PAID	29. BALANCE DUE
SIGNED _____		DATE _____		30. YOUR SOCIAL SECURITY NO.		31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.	
32. YOUR PATIENT'S ACCOUNT NO.				33. YOUR EMPLOYER I.D. NO.		I.D. NO.	

- * PLACE OF SERVICE CODES 12 - (H) - PATIENT'S HOME 32 - (NH) - NURSING HOME O - (OL) - OTHER LOCATIONS
 21 - (IH) - INPATIENT HOSPITAL 52 - DAY CARE FACILITY (PSY) 31 - (SNF) - SKILLED NURSING FACILITY 81 - (IL) - INDEPENDENT LABORATORY
 22 - (OH) - OUTPATIENT HOSPITAL 6 - NIGHT CARE FACILITY (PSY) 41 - AMBULANCE 24 - OTHER MEDICAL/SURGICAL FACILITY
 11 - (OL) - DOCTOR'S OFFICE