



Coventry Health Care of Nebraska, Inc.
Coventry Health and Life Insurance Company

Medical Claim Form

Instructions for filing claim

- 1. Insured completes this side of form for medical claims.
2. Attach itemized bills or have attending physician complete the reverse side.
3. Send the completed form and bills to the address given on your medical card.

Group Plan No. _____

Group Name _____

See reverse side for address to mail claims

To be completed by Primary Subscriber

1 _____
Please Print Last Name First Middle
Male Female

Home Address _____

City, State, ZIP Code Home Phone Number _____

Date of Birth _____

Subscriber No. _____

4 Yes No
Is this a dependent claim? If so, please fill out this box.

Form for dependent claim information including fields for Full Name of Dependent, Date of Birth, Relationship to Employee, and gender options.

2 Yes No
Is this illness or injury work related?
3 Yes No
Was this an injury due to an accident? If so, please give the details. (For possible third party liability)

5 Yes No
Are you married?
Yes No
Is your spouse employed? If so, you must fill out this box.

Date of Accident Where Did Accident Occur?

Describe the accident fully: _____

5a Spouse's Birth Date Spouse's Social Security No.
Name of Spouse's Employer
Address of Spouse's Employer

6 Yes No
Are you or your dependent insured under any other group medical expense plan, Medicare or Tricare? If so, please fill out this box.

I authorize payment of benefits to the physician or supplier.
Subscriber Signature Date

6a Other Policy Number Name of Other Insurance Company or Plan
Address of Other Insurance Company's Claims Settlement Office

I/We certify that the above information is true and correct, and authorize any union, trust fund, employer, insurance carrier, physician or hospital to furnish information to Coventry Health Care about any other benefits to which I/we may be entitled.
Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.
Employee's Signature Date

Attending Physician Statement

Do not complete this section if you are attaching itemized bills that contain all the needed information.

PHYSICIAN OR SUPPLIER INFORMATION									
1. DATE OF		ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		2. DATE YOU WERE FIRST CONSULTED FOR THIS CONDITION		3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE PATIENT ABLE TO RETURN TO WORK		5. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____			7. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____				
6. NAME OF REFERRING PHYSICIAN				9. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES:					
8. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				10. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. <u>RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2 OR DX CODE</u> 1. 2.					
A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D DIAGNOSIS CODE	E CHARGES		F		
		PROCEDURE CODE	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)		AMOUNT PAID	BALANCE DUE			
12. SIGNATURE OF PHYSICIAN OR SUPPLIER				13. TOTAL CHG.		14. TOTAL AMT. PD.		15. TOTAL BAL. DUE	
SIGNED _____ DATE _____				16. YOUR SOCIAL SECURITY NO.		17. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. I.D. NO.			
18. YOUR PATIENT'S NAME AND ACCOUNT NO.				19. YOUR EMPLOYER I.D. NO.					

***PLACE OF SERVICE CODES**

- 1 - (IH) - INPATIENT HOSPITAL
- 2 - (OH) - OUTPATIENT HOSPITAL
- 3 - (O) - DOCTOR'S OFFICE

- 4 - (H) - PATIENT'S HOME
- 5 - - DAY CARE FACILITY (PSY)
- 6 - - NIGHT 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

Mail Medical Claims to:
The address on your
Identification Card