Medical Claim Form

Please use a separate claim form for each patient and provider. Your cooperation in completing all items on the claim form and attaching all required documentation will help expedite quick and accurate processing. SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS.

SECTION 1: PATIENT INFORMATION

Last name	First name	M.I.

Does the patient have other health insurance coverage?	Relation to subscriber	Sex	Date of birth (MM/DD/YYYY)
☐ Yes ☐ No	☐ Self ☐ Spouse ☐ Son ☐ Daughter	☐ Male ☐ Female	

Name of other health insurance company	Group no.	Employer name	Policy no.

SECTION 2: SUBSCRIBER INFORMATION (on member ID card)

Identification no.	Group no.

Last name	First name	M.I.

Street address (please include apt. no.)	City	State	ZIP code

Home phone no.	Work phone no.	Date of birth (MM/DD/YYYY)

SECTION 3: MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to **HealthLink** by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) **Attach itemized bill or photocopy.** Please be sure that duplicate bills are not submitted.

Where was the service rendered? ☐ Physician office ☐ Outpatient ☐ Inpatient ☐ Ambulance ☐ Medical equipment supplier ☐ Pharmacy ☐ Laboratory ☐ Other

Was this medical expense the result of an accident? ☐ Yes ☐ No

Was this condition or injury job related? ☐ Yes ☐ No

Have you filed for Workers' Compensation? ☐ Yes ☐ No

When did this injury or accident occur? (MM/DD/YYYY)

Date of service	Diagnosis code	Procedure code	Tax ID	Amount
			Total	$ 0.00

BILLS MUST BE ITEMIZED

Cancelled checks, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

- Name and address of provider (doctor, hospital, laboratory, ambulance service, etc.)
- Name of patient
- Service provided
- Date of service
- Amount charged for each service
- Diagnosis code
- Procedure code
- Tax ID
- NPI

I certify that, to the best of my knowledge, the information on this Medical Claim Form is true and correct. I authorize the release of any medical information necessary to process this claim.

Signature	Printed name	Date (MM/DD/YYYY)
X		

HOW TO USE THIS FORM

Dear Member:

Usually, all providers of health care will bill us for services to you and your enrolled dependents. This is the preferred procedure. You are not bothered with claim forms and we often need more details than are ordinarily provided on bills to patients.

Sometimes, a physician or an ambulance company may not bill us, for example, they may send the bill directly to you. In either instance, we have no way of knowing about your claim. This Medical Claim Form was developed to notify us of any covered health service for which we have not already been billed. Please read the following instructions about how to report Health Care Services.

We are happy to serve you.

SECTION 1: PATIENT INFORMATION

Use this section to identify the patient.

SECTION 2: SUBSCRIBER INFORMATION (on member ID card)

Use this section to identify the subscriber. Some of this information may be found on your **ID** card.

SECTION 3: MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service that has not already been reported to **HealthLink** by the provider of service (the physician, clinical, ambulance company, private duty nurse, etc.) **Attach itemized bill or photocopy.** Please be sure that duplicate bills are not submitted.

HealthLink Medical Claim Form Instructions:

Please send claims to:

HealthLink
P.O. Box 411580
St. Louis, MO 63141

If you have questions or need any assistance, please call the number listed on your Member ID card.