Cleveland Health Network

MUTUAL HEALTH SERVICES℠

HEALTH CARE CLAIM FORM

EMPLOYEE HEALTH PLAN

PLEASE SUBMIT ALL CLAIMS TO:
P.O. Box 89472
Cleveland, Ohio 44101-6472

NOTICE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud, submits an application for coverages or files a claim containing a false, misleading or deceptive statement is guilty of insurance fraud. Criminal and/or Civil penalties can result from such acts.

For **ALL** claims—this area must be filled out completely

EMPLOYEE

Employee's Name (Please Print Full Name)
Last First Middle Initial

Employee's ID Number

Address

Marital Status: (check one)
☐ Single ☐ Married ☐ Widowed ☐ Divorced

Name of Spouse:

Is your spouse employed: ☐ Yes ☐ No

City State Zip

If this is a new address, contact your employer's personnel office to make the appropriate changes

Name and address of Company where spouse is employed:

Employee's Date of Birth
Month / Day / Year

If the patient is a dependent, please complete all of the following. If the patient is the employee, go directly to the area below

PATIENT INFORMATION

Patient's Name (if other than employee)
Last First Middle

Patient's Date of Birth
Month / Day / Year

Relationship to employee
☐ Spouse ☐ Child

If child, is (s)he married?
☐ Yes ☐ No

Date accident occurred or sickness began
Month / Day / Year

Description of injury or sickness

Was injury due, in any way, to patient's occupation?
☐ Yes ☐ No

Place of accident (check one)
☐ Auto ☐ Work ☐ Home ☐ Other _____

If accident, date and how it occurred

If yes, Explain:

Is Patient Covered by Another Plan? ☐ Yes ☐ No

Any Group Insurance, Blue Cross-Blue Shield or any other pre-payment arrangement maintained on a group basis? ☐ Yes ☐ No

Any other coverage provided by an employer or any federal state of other governmental agency? ☐ Yes ☐ No

_____

_____

If eligible, is person enrolled in:

Medicare Part A ☐ Yes ☐ No Effective Date of Part A is _____

Medicare Part B ☐ Yes ☐ No Effective Date of Part B is _____

RELEASE

AUTHORIZATION TO RELEASE INFORMATION—I hereby authorize any physician, hospital, clinic, dispensary, sanitarium, druggist, or any other Provider (including other insurance companies), Employer or Organization to release any information or view a copy of my records pertaining to the examination, treatment, history, prescriptions or medical expenses to Antares Management Solutions or its representatives, for the purpose of validating and determining benefits payable in connection with the claim.

_____ _____

PATIENTS SIGNATURE *(Parent or Guardian if Claim is on a Minor)* **DATE**

By my signature, I acknowledge that payment of this claim is subject to the Plan's rights of subrogation and reimbursement, and to the coordination of benefits with any other coverage that the patient may have. Furthermore, I certify that the forgoing information is true and correct.

PAYMENT

PAYMENT AUTHORIZATION—If you participate in a Preferred Provider benefit plan design, your provider should not require you to pre-pay for services covered under you employers' health care benefit plan. Make sure the provider's office is aware that you participate in a Preferred Provider plan and present them with your plan identification card.

I hereby authorize payment of these benefits be sent directly to: ☐ PROVIDER OF SERVICE ☐ EMPLOYEE (attach proof of payment)

_____ _____

EMPLOYEES SIGNATURE **DATE**

IMPORTANT:CLAIMS CANNOT BE PAID UNTIL THE CLAIM FORM IS PROPERLY COMPLETED AND RECEIVED.

Do not send this form through your employer. **ATTACH PROVIDER BILLING.**

If you require assistance in presenting this claim, call Customer Service at:1-800-451-7929.