AmeriHealth Administrators

Medical Claim Form

Send all medical claims to:
AmeriHealth Administrators
PO Box 21545
Eagan, MN 55121

1 – MEMBER / PATIENT

Member's name (First, Middle, Last)	Identification #	Group #
Present address - Street ❑ New address	City	State

Patient's name (First, Middle, Last)	Patient's relationship to member	Sex	Birth date
	❑Self ❑Spouse ❑Child ❑Handicapped dependent ❑Other	❑M ❑F	____/____/____

2 – OTHER INSURANCE

Does the **patient** have other health insurance coverage? ❑Yes ❑No If YES, complete the rest of Section 2.

Policyholder's name (First, Middle, Last)	Birth date	Policyholder's employment status
	____/____/____	❑Active ❑Disabled ❑Retired ❑Effective date: ____/____/____

Policyholder's relationship to member	Other insurance carrier's name	Identification #	Effective date
❑Self ❑Spouse ❑Child ❑Other			____/____/____

Type(s) of coverage (Check all that apply.) ❑Hospitalization ❑Medical-surgical ❑Dental ❑Vision ❑Drug ❑Major medical ❑Other (Specify.) _____

Contract covers ❑Policyholder only ❑Policyholder and spouse ❑Policyholder and child(ren) ❑Family

Is the **patient** entitled to benefits under **Medicare** Part A or B? ❑Yes ❑No If YES, complete the rest of Section 2.

Medicare effective date _____/_____/_____ Medicare ID # _____

Member's employment status ❑Active ❑Retired ❑Disabled

3 – PATIENT'S CONDITION

a. Describe the **conditions** for which you are requesting coverage.

Type of injury or illness	Name of doctor treating injury/illness	Date of first symptoms
_____	_____	_____/_____/_____
_____	_____	_____/_____/_____

b. If this claim is the result of an injury, do you intend to file a claim against another individual, business, organization, or insurer for damages arising from the injury? ❑Yes ❑No

c. If this claim is the result of an injury, have you retained an attorney to represent you? ❑Yes ❑No

d. Were the services related to a hospitalization? ❑Yes ❑No If YES, complete the rest of Question 3d.

Admission date _____/_____/_____ Discharge date _____/_____/_____

Hospital name _____ Admitting physician _____

e. Were the expenses due to an accident? ❑Yes ❑No If YES, complete the rest of Question 3e.

Accident date _____/_____/_____ ❑Work ❑Auto ❑School ❑Other (Specify.) _____

f. Is this claim for prescription drugs? ❑Yes ❑No If YES, complete the rest of Question 3f.

Pharmacy name _____ Address _____

NDC Number (Obtain this number from your pharmacist.) __ __ __ __ __ - __ __ __ __ - __ __

4 – AUTHORIZATION

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits actually incurred by the named patient. I authorize any hospital, physician, or other provider who participated in the care and treatment of the patient to release all medical or other information requested for the processing of the claim to AmeriHealth Administrators. I hereby agree to reimburse AmeriHealth Administrators in full if this claim is paid incorrectly. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

MEMBER SIGNATURE	DATE	(AREA CODE) HOME PHONE	(AREA CODE) WORK PHONE
_____		_____	_____