

Member Claim Form



UNICARE Life & Health Insurance Company

Please use a separate claim form for each patient. Your cooperation in completing all items on the claim form and attaching all required documentation will help us to process your claim quickly and accurately.

PLEASE TYPE OR PRINT • SEE REVERSE SIDE FOR COMPLETE INSTRUCTIONS

PATIENT INFORMATION			INSURED INFORMATION (on ID Card)			
NAME Last		First	Middle	CERTIFICATE NUMBER		GROUP NAME
BIRTHDATE	SEX M F	RELATION TO SUBSCRIBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter		NAME Last		First Middle
DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO			ADDRESS			
NAME OF OTHER HEALTH INSURANCE COMPANY			CITY	STATE	ZIP CODE	
POLICY NUMBER			HOME PHONE NO.	WORK PHONE NO.		

MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service which has not already been reported to this HTH Worldwide Plan by the provider of service (the physician, clinic, ambulance company, private duty nurse, etc.) Attach itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance forward bills or canceled checks are not acceptable.

Was this medical expense the result of a motor vehicle accident? YES NO If yes, indicate date: Month ___ Day ___ Year ___

Was this condition or injury job related? YES NO If yes, have you filed for Workers' Compensation? YES NO

Was this condition or injury the result of or caused by the patient's participation in a sport? YES NO

Have you been treated for the same condition within the last 24 months? YES NO

If yes, indicate date treatment began and date you were last treated: Began: M ___ D ___ Y ___ Last: M ___ D ___ Y ___

Were you referred by another physician or health care provider for these services? YES NO

If yes, please indicate referring physician or health care provider name and address:

Dr: _____

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, etc.)	SERVICE RENDERED (Office Visit, X-ray, etc.)	ILLNESS OR DIAGNOSIS	TOTAL

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I certify that the information on this Member Claim Form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. SIGNATURE REQUIRED. This claim will be returned if this claim form is not signed.

GRAND TOTAL
\$

X _____
 SIGNATURE OF SUBSCRIBER DATE

IF PAYMENT IS TO BE MADE TO THE PROVIDER, SIGN BELOW

Except where the Plan provides for automatic payment of benefits to the provider of services, I hereby authorize payment directly to the provider of service for the enclosed expenses as provided under the Plan. I understand I am financially responsible for charges not covered by the Plan.

X _____
 SIGNATURE OF SUBSCRIBER DATE

INSTRUCTIONS FOR THE USE OF YOUR CLAIM FORM

Dear Member:

Normally, providers of health care will bill us directly for services to you and your enrolled dependents. This is the preferred procedure. When your health care provider bills us, you do not need to send us a claim form.

If a physician, ambulance company or other provider sends their bill directly to you, we have no way of knowing about your claim until we have received your bill at HTH Worldwide. This Member Claim Form was developed for you to notify us of any covered health services 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.

PATIENT INFORMATION

INSURED INFORMATION (on ID Card)

Use this section to identify the patient and policyholder. Some of this information may be found on your HTH Worldwide ID card.

MEDICAL INFORMATION

HEALTH CARE SERVICES: Use this section to report any COVERED health service which has not already been reported to HTH Worldwide by the provider of service (the physician, clinic, ambulance company, private duty nurse, etc.) Attach the itemized bill or photocopy. Please be sure that duplicate bills are not submitted. Balance-forward bills or canceled checks are not acceptable.

DATE OF SERVICE (Mo/Day/Yr)	PROVIDER OF SERVICE (Name of Doctor, Lab, etc.)	SERVICE RENDERED (Office Visit, X-ray, etc.)	ILLNESS OR DIAGNOSIS	TOTAL
7/9/01	John Wong, M.D.	Office Visit	Bronchitis	\$35.00
8/11/01	Pat Fogerty, M.D.	X-ray	Strain	\$57.00
GRAND TOTAL				\$92.00

THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THE SERVICE TYPES LISTED BELOW

REGISTERED AND LICENSED VOCATIONAL NURSING SERVICES

- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT

- Doctor's orders or prescriptions
- Purchase price

OUTPATIENT PRESCRIPTION DRUGS

- Duplicate pharmacy generated receipt (not register tape)
- Must include Rx Number; Date Filled, Medication Name, Form, Strength & Quantity

AMBULANCE

- Pick-up and delivery points
- Number of miles

ANESTHESIA

- Start Time
- End Time
- Surgical procedure
- Surgeon Name and address

BILLS MUST BE ITEMIZED

Canceled check, 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.)
- Provider taxpayer I. D. number
- Name of patient
- Date(s) of service
- Amount charged for each service
- Total Charge
- Diagnosis or reason for treatment

SEND COMPLETED CLAIM FORMS, WRITTEN INQUIRIES AND ADDRESS CHANGES TO:

HTH Worldwide Insurance Services
PO Box 39
Minneapolis, MN 55440-0039
WebMD Payor ID 41170