INCLUSIVE HEALTH

Complete Claim Form and Return To:

Inclusive Health
P.O. Box 2920
Clinton, IA 52733
(866) 665-2117

Medical Claim Form

Member Information: (TO BE COMPLETED IN DETAIL BY THE MEMBER)

1. Name of Member	2. Member Social Security Number	3. Date of Birth

4. Address of Member (Street, City, State and Zip Code)	5. New Address?	6. Sex
	☐ yes ☐ no	☐ M ☐ F

7. Name of Member's Employer or School	8. Address of Member's Employer or School

9. If Your Claim Is Due To An Accident, Answer The Following:	10. If Your Claim Is Due To An Illness, Answer The Following:
When Did It Happen? _____ Where Did It Happen? _____ How Did It Happen? _____ Was The Accident Connected With Your Work? _____ If Auto Accident, Who Was At Fault? _____ _____	When Did The Symptoms Begin? _____ Where Did You First See A Doctor For It? _____ _____ Name And Address Of Doctor _____ _____ _____

11. IS THE MEMBER COVERED BY ANY OTHER MEDICAL COVERAGE? ☐ Yes ☐ No

If Yes, Please Give The Complete Information About The Coverage In The Space Below

Name And Address Of The Other Insurance Company	Name Of Employer, Group Or School Providing The Plan	Name Of The Insured Person	Policy Number Or Cert. No.

(FAILURE TO LIST OTHER INSURANCE OR MEDICAL BENEFITS MAY CONSTITUTE FRAUD PUNISHABLE BY IMPRISONMENT)

12. I CERTIFY THE STATEMENTS ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

(Member's Signature)

13. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Hospital or Physician to release information required in the course of my examination or treatment which may be necessary to determine benefits payable under this plan. (A photostatic copy of this authorization is as valid as the original)	Signed (Member Signature)	DATE
14. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician and/or Hospital providing services for which benefits are payable. This assignment will be honored only when the claim form from the provider does not contain any assignment of benefits or an indication that one is on file.	Signed (Member Signature)	DATE

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HOW TO FILE A CLAIM

1. Complete **MEMBER INFORMATION** section of form. 2. Have attending Physician complete this side of form (or attach itemized bill) and return to you. 3. Attach itemized bills for medical expenses such as hospital, radiologist, pathologist, anesthesiologist and other covered charges. 4. A separate claim must be completed for each covered person. 5. Forward completed form and bills to address shown on the reverse side of this form.

ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis (If diagnosis code other than ICDA* used, give name)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ Yes ☐ No	PREGNANCY? ☐ Yes ☐ No	If Yes, approximate date pregnancy commenced._____

3. REPORT OF SERVICES (or attach itemized bill) (If previous form submitted, you need show only dates and services since last report)

Date Of Services	Place Of Services	Description Of Surgical Or Medical Services Rendered	Procedure Code - If Used (If code other than CPT** used, give name)	Charges

HOSPITAL CONFINED FROM _____ to _____

☐ - Doctor's Office IH - Inpatient Hospital NH - Nursing Home
H - Patient's Home OH - Outpatient Hospital OL - Other Locations

* ICDA -- International Classification of Diseases
** CPT -- Current Procedural Terminology (Current edition)

TOTAL CHARGES $ _____

AMOUNT PAID $ _____

BALANCE DUE $ _____

4. DOES PATIENT HAVE OTHER HEALTH INSURANCE? ☐ Yes ☐ No If "Yes" please identify	5. I DO NOT ACCEPT ASSIGNMENT. ☐
6. PHYSICIAN'S NAME (PRINT) DEGREE DATE	9. INDIVIDUAL PRACTITIONER'S - SS _____ ALL OTHERS - EMPLOYER I.D. _____ MUST BE FURNISHED UNDER AUTHORITY OF LAW
7. PHYSICIAN'S SIGNATURE TELEPHONE	

8. STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE