# 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 |
|---|---|---|---|
| _____ | | _____ | _____ |

## INSTRUCTIONS

Your provider may submit claims directly to AmeriHealth Administrators. You should submit this claim form only when your provider does not submit a claim for you.

1. Please attach itemized bills to this claim form. These bills should include the following information:

    - Name, address, and telephone number (on official bill head) of the **provider** who rendered the service or supplied the item
    - **patient's** full name
    - **description** of each service rendered or item supplied
    - **date and amount charged** for each service rendered or item supplied
    - **diagnosis** of the ailment

2. Please be sure that a **physician's medical certification** accompanies bills for purchase or rental of medical equipment

3. Please complete the claim form carefully, and be sure to include the information requested above. This will help avoid unnecessary delays in processing your claim.

4. You do not need to submit a claim form for prescription drug purchases made at network pharmacies. The pharmacist will file the claim for you. If you purchase your prescription at a non-network pharmacy, you may still be entitled to reimbursement for a portion of your prescription drug expenses by completing Section 3 of this claim form. Be sure to include itemized receipts for each prescription. Remember to ask your pharmacist for the NDC number of the drug you purchased, and record that number in Section 3 on the front of this form.