## PLEASE CHECK IF NEW ADDRESS

## HealthSmart SMARTER HEALTHCARE SOLUTIONS

## ANNUAL MEDICAL CLAIM NOTICE

ENROLLEE: TO AVOID DELAYS PLEASE FOLLOW THESE INSTRUCTIONS.

1. COMPLETE ONE FORM ANNUALLY FOR YOU AND/OR YOUR FAMILY UPON YOUR FIRST CLAIM SUBMISSION.

4. IF YOU HAVE ANY QUESTIONS, DIRECT TO:

2.		SIDE OF THIS FO		LETED BY PRIMARY P	HYSICIAN. (ASK OTHER	PROVIDERS	FOR					
3.	FOR ADDITIONA	L CLAIM SUBMIS	SIONS, CO	MPLETE A SUBSEQUE	NT CLAIM NOTICE.							
I. GR		N										
GRO	JP NAME								GROUP NUM	BER		
GROUP ADDRESS						CITY			STATE		ZIP	
II. EN	ROLLEE INFORM	ATION: COMPLET	E FOR AL	L CLAIMS								
4.	ENROLLEE N	ENROLLEE NAME: FIRST MI			LAST SEX MALE FEMALE			5. SOCIAL SECURITY NO.			6. DATE OF BIRTH	
7.	HOME ADDRESS: STREET			CITY	CITY			ZIP			SINGLE MARRIED	
9.	HIRE DATE: 10. ARE YOU STILL ENROLLED IN PLAN? YES				11. IF NO, DATE OF TEP	DATE OF TERMINATION: 12. DATE YOU BECAME RET			TIRED: 13. DATE COBRA COVERAGE BECAME EFFECTIVE:			
14.			COVERAGE? IF YES, COMPLETE			COMPLETE BOX	E BOXES #26 & 27 BELOW.					
III. DE	PENDENT INFOR	MATION: COMPL	ETE FOR				-					
16.		DEPEN	IDENT NAM	IE	RE	(	TO ENROLI POUSE CHILD CHILD CHILD		SEX / F-Female		DATE OF BIRTH	
17.	IF DEPENDEN	T CHILD IS OVER	AGE 19, F	ROVIDE NAME AND AD	DRESS OF SCHOOL:					18. C	URRENT TERM ENROLLED FOR:	
	PROVIDE THE EMPLOYMEN FOR SPOUSE	<b>INFORMATION</b>	19	SPOUSE'S NAME:				20. SOCIAL S	SECURITY NO .:		21. BIRTHDATE:	
22.	SPOUSE'S EN				23. ADDRESS						24. PHONE NUMBER	
25.	PROVIDE THE EMPLOYER N AND ADDRES	AME	PLOYMEN	Information for P	ATIENT, IF DEPENDENT	CHILD:						
26.					RE, AUTOMOBILE COVER				ICAL EXPENSES	OR DISAB	ILITY LOSSES AT TIME	
27. IF OT	COVERAGE P HER PERSON: N/	ROVIDED THRU: AME:	C	SPOUSE CHILD	OTHER PERSON		US EMPLOY		ELATIONSHIP:			
	CO. NAME:											
	RESS:	<u>.</u>					CERTIFIC					
		TH OTHER CARRI	ER:				CERTIFICA		ATTACH PA	YMENT REC	CORD IF AVAILABLE	
IV. CI	AIM INFORMATIC	ON: COMPLETE F	OR ALL CL	AIMS								
28.	PATIENT'S NA	ME:			29. RELATIONSHIP	TO ENROLI	.EE:	30. PATIENT'S	SEX:	31. PA	TIENT'S DATE OF BIRTH:	
32.	IS CLAIM DUE TO:  ILLNESS ACCIDENT/GIVE DESCRIPTION									33. IS INJURY/ILLNESS RESULT OF EMPLOYMENT? YES NO		
	IF ACCIDENT THE FOLLOW		34. DA	E AND TIME OF ACCID	ENT:	35. LOCA	ATION OF AC	CIDENT:				
36.	CAUSES OF A	CCIDENT:										
37.				GENCE OF THIRD PAR PRODUCT, AUTO ACCI	TY DENT)? YES 🗆 NO 🛙			AUTO ACCIDENT, YES D NO D	IS NO-FAULT IN	SURANCE	APPLICABLE?	
V. MA	NDATORY AUTH	ORIZATION SIGNA	TURE									
CLAI	ADMINISTRATO	rs, insurers, re Ch other with i	EINSURER NFORMAT	5, AND OTHERS WHO H ON ABOUT MY HEALTH	AVE A LEGITIMATE NEED	O FOR SUCH	INFORMATI ES PROVIDE	on for the pup ed to me. I furt	RPOSE OF REVI	EW, INVEST REIMBURS	H CARE SERVICES, SUPPLIERS, IGATION, OR EVALUATION OF A E THE PLAN TO THE EXTENT OF HE ORIGINAL.	
ENROLLEE'S SIGNATURE							the second district			DATE		
SPOUSE'S SIGNATURE (FOR SPOUSE OR CHILD'S CLAIM)							_			DATE		

PART 1			TO BE COMPLETED BY ENROLLEE								
PATIENT'S NAME /	AND ADDRESS					C	ATE OF BIRTH				
payment directly to	the Provider of the	S TO THE PROVIDER. I hereby an Surgical and/or Medical Benefits,	if any,	ENROLLEE)							
		ces as described below or on the a customary charge for those service				DATE					
AUTHORIZATION <sup>-</sup> undersigned Physic examination or trea	ian to release any	ORMATION: I hereby authorize the information acquired in the course		ENROLLEE)							
PART 2		T				DATE	asso Print or 7				
1. DATE OF		LNESS (FIRST SYMPTOM) OR	2. DATE FIRST CONSULTED YOU FOR	3. HAS P		Please Print or T					
I. DATE OF		IJURY (ACCIDENT) OR REGNANCY (LMP)	THIS CONDITION	OR SI	MILAR CONDITION? $\Box$ NO		MENT?				
5. DATE PATIEN WORK	IT ABLE TO RETU	IRN TO 6. DATE OF TOTAI	DISABILITY	7. DATE	LITY						
	FERRING PHYSIC		THROUGH	FROM         THROUGH           9. FOR SERVICES RELATED TO HOSPITALIZATION GIVE							
5. NAME OF RE		CIAN		ADMITTED DISCHARGED							
10. NAME & ADD	RESS OF FACILIT	TY WHERE SERVICES RENDERI	ED (if other than home or office)	11. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFIC							
			NOSIS TO PROCEDURE IN COLUMN BY REFE		SERS 1 2 3 ETC OF						
4. 13. A DATE OF	B* PLACE OF	SUPPLIES FURNISHED F		D ICD-9 E		F					
SERVICE	SERVICE	PROCEDURE CODE (IDENTIFY)	(Explain Unusual Services or Circumstances)	DIAGNOSIS CODE	CHARGES						
14. SIGNATURE OF PHYSICIAN OR SUPPLIER			15. ACCEPT ASSIGNMENT	16. TOTAL CHARGES		17. AMT. PAID	18. AMT. DUE				
			□ YES □ NO	20. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS,							
			19. YOUR SOCIAL SECURITY NO.	20. FITTOICIAN	I ON OUF PLIER O INA	NINE, ADDINEGO, ZIP U	UL & ILLEFIONE				
SIGNED		DATE									
21. YOUR PATIENT	I'S ACCOUNT NO		22. YOUR EMPLOYER I.D. NO.	7							

## \*PLACE OF SERVICE CODES

1 - (IH) -Inpatient Hospital2 - (OH) -Outpatient Hospital3 - (O) -Doctor's Office

4 - (H) - Patie 5 - Day 6 - Nigh

Patient's Home Day Care Facility (PSY) Night Care Facility 7 - (NH) -Nursing Home8 - (SNF) -Skilled Nursing Facility9 -Ambulance

O - (OL) -A - (IL) -B -

Other Locations
 Independent Laboratory
 Other Medical/Surgical Facility