

**CLAIM FORM
GROUP POLICY
285631**



<input type="checkbox"/> CHECK HERE IF NEW ADDRESS SINCE LAST SUBMISSION. DATE RELOCATED ____/____/____
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FORWARD COMPLETED CLAIM FORM TO: RURAL CARRIER BENEFIT PLAN
PO BOX 14079
LEXINGTON, KY 40512-4079

Phone: (800) 638-8432

PLEASE PRINT

TO BE COMPLETED BY INSURED MEMBER
All items must be answered in full before your claim can be processed.

PLEASE PRINT

Member's full name _____ Sex _____ Date of Birth _____

Member's mailing address _____
(Number and Street) (City) (State) (Zip Code)

Member's Subscriber ID _____ Enrollment Code (please check one) Self Only 381 Self & Family 382
 Self Plus One 383

If claim is for a dependent, given name _____ Relationship _____ Date of Birth _____

Dependent's marital status (check one) single married

Describe Sickness/Accident Suffered _____

If Accident: (a) Date of accident _____
(Month) (Day) (Year) (Hour)

(b) How and where did accident occur? _____

Was accident or sickness work related? Yes No If "Yes" please contact your workers' compensation office for guidance.

Physician's Name _____ Address _____

OTHER INSURANCE/MEDICARE COVERAGE INFORMATION

(See section on coordination of benefits in your Brochure)

IMPORTANT: This question must be answered and the form signed before claim can be processed.

(a) Are you or any member of your family covered under any health plan other than Rural Carrier Benefit Plan? Yes No

(b) If answer is "Yes", complete the following:

Person in whose name the other plan is issued _____

Name of all dependents covered under the other plan _____

Name of Insurance Company or Plan _____ Effective Date _____

Address of Claims Office _____

Is this insurance through active employment? _____ Employment Effective Date _____

Policy or Contract Number _____ Is Plan Family or Self only coverage? (Check appropriate block)

(c) Is this other plan issued under a Group or Individual contract? (Check appropriate block)

IMPORTANT: This question must be fully answered by persons age 65 or older and persons under age 65 receiving disability benefits through Social Security.

Medicare coverage (see your official Brochure)

(a) Are you or any member of your family covered under Medicare? Yes No

(b) If "Yes", indicate name of person and check the type of coverage.

SELF: _____ Hospital (Part A) Effective Date _____ Medicare (Part B) Effective Date _____

SPOUSE: _____ Hospital (Part A) Effective Date _____ Medicare (Part B) Effective Date _____

DEPENDENT: _____ Hospital (Part A) Effective Date _____ Medicare (Part B) Effective Date _____

(c) If you or your spouse are 65 or over, indicate whether you are actively employed.

Self: Yes No Employer _____

Spouse: Yes No Employer _____

Authorization for direct payment of benefits.	I authorize payment directly to _____ (Print name of physician) for the Medical and/or Surgical Benefits otherwise payable to me. Date _____, 20____ Signed _____ (Signature of member)
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I certify the information on this form is complete and accurate.

Signature of patient or member	Date
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WARNING: Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than \$10,000, or imprisonment of not more than five years, or both. (18 U.S.C. 1001)

HAVE YOU ANSWERED EVERY QUESTION? _____ HAVE YOU DATED AND SIGNED THIS FORM? _____



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (ID #/DoD#) CHAMPVA <input type="checkbox"/> (Member ID #) GROUP HEALTH PLAN <input type="checkbox"/> (ID #) FECA BLK LUNG <input type="checkbox"/> (ID #) OTHER <input type="checkbox"/> (ID #)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (Number, Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										6. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (Number, Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current of Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										10d. CLAIM CODES (Designated by NUCC)										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a and 9d</i>									
b. RESERVED FOR NUCC USE										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
c. RESERVED FOR NUCC USE										14. DATE OF CURRENT ILLNES, INJURY or PREGNANCY (LMP) MM DD YY QUAL. _____										15. OTHER DATE MM DD YY QUAL. _____									
d. INSURANCE PLAN NAME OR PROGRAM NAME										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)									
14. DATE OF CURRENT ILLNES, INJURY or PREGNANCY (LMP) MM DD YY QUAL. _____										15. OTHER DATE MM DD YY QUAL. _____										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ ICD Ind. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										23. PRIOR AUTHORIZATION NUMBER										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID QUAL J. RENDERING PROVIDER ID #									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____ ICD Ind. _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID QUAL J. RENDERING PROVIDER ID #										25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> 26. PATIENT'S ACCOUNT NUMBER 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC use									
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25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/> 26. PATIENT'S ACCOUNT NUMBER 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC use										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH. # () a. NPI b. _____									

SECOND FOLD

FIRST FOLD

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual Available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-1

GC-16438 (12-17)