CLAIM FORM
GROUP POLICY
237588

FORWARD COMPLETED CLAIM FORM TO:

Phone: (800) 638-8432

RURAL CARRIER BENEFIT PLAN
PO BOX 14079
LEXINGTON, KY 40512-4079

☐ **CHECK HERE IF NEW ADDRESS SINCE LAST SUBMISSION. DATE RELOCATED** ____/____/____

PLEASE PRINT — **TO BE COMPLETED BY INSURED MEMBER** — **PLEASE PRINT**

All items must be answered in full before your claim can be processed.

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 79A ☐ Self & Family 79B ☐ Self Plus One 79C

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)

I certify the information on this form is complete and accurate.

Signature of patient or member	Date

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

PICA | PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (ID #/DoD#) CHAMPVA ☐ (Member ID #) GROUP HEALTH PLAN ☐ (ID #) FECA BLK LUNG ☐ (ID #) OTHER ☐ (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 ☐ M ☐ F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (Number, Street)

6. PATIENT'S RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (Number, Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

PATIENT AND INSURED INFORMATION

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current of Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX ☐ M ☐ F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, complete items 9, 9a and 9d

SECOND FOLD

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 _____

14. DATE OF CURRENT ILLNES, INJURY or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E) ICD Ind.

A. _____ B. _____ C. _____ D. _____

E. _____ F. _____ G. _____ H. _____

I. _____ J. _____ K. _____ L. _____

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

FIRST FOLD WHCF-10 ENV / WHCF-10-ENV-SS

PHYSICIAN OR SUPPLIER INFORMATION

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) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NUMBER

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC use

31. SIGNATURE OF PHYSICAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. **NPI** b.

33. BILLING PROVIDER INFO & PH. # ( )

a. **NPI** b.

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