MEDICAL CLAIM FORM

Please return this form to Healthcare Management Administrators (HMA) by mail or fax:

<u>Please include copies of receipts for each claim and documentation from your provider showing procedure and diagnosis codes.</u>

Mail: HMA
Attn: Claims Department
PO Box 85008
Bellevue WA 98015

Fax: 1-866-458-5488

SECTION 1 – EMPLOYEE INFORMATION		
Employee Name:		Member ID Number:
Address:		Is this an address change: ☐ Yes ☐ No
Phone Number: ( )	Employee's Date of Birth:	Group Name and Group Number:
Marital Status: ☐ Single ☐ Widowed ☐ Legally Separated ☐ Divorced ☐ Married If married, provide name of spouse:		
If you are divorced and the claim(s) are for a dependent child or children, please answer these questions: Is this child (or children) in your permanent custody? ☐ Yes ☐ No Is there a court order for provision of medical care for this child (or children)? ☐ Yes ☐ No		
SECTION 2 – PATIENT INFORMATION		
Patient Name:	Patient is: ☐ Employee ☐ Spouse ☐ Child ☐ Other If other, specify:	
Address:		
Phone Number: ( )	Patient's Date of Birth:	
If claim(s) are for a dependent over age 19, is the dependent a full-time student? ☐ Yes ☐ No If yes, attach proof of student status and identify it here:		
SECTION 3 – DESCRIPTION OF CLAIM		
Description of Illness or Injury:		
Is this a work-related illness or injury? ☐ Yes ☐ No If yes, did you file or will you be filing a claim with Labor & Industries (L&I)? ☐ Yes ☐ No		
If claim is due to an accident, state when, where, and how the accident occurred:		

Continued on Next Page

CONFIDENTIAL
This document contains sensitive information that is confidential to the addressee and should not be copied, distributed or reproduced in whole or in part.

SECTION 4 – OTHER GROUP HEALTH INSURANCE

Are you or any of your family members covered by other insurance for medical, dental, or vision benefits?
☐ Yes ☐ No

Check only those covered by other group insurance: ☐ Self ☐ Spouse ☐ Dependent(s)

If spouse, provide date of birth: _______________

If dependent(s), list name(s): ____

Name and address of other insurance carrier:

Phone number of other insurance carrier:	Policy Number:	Effective Date:

Is patient eligible for Medicare benefits? ☐ Yes ☐ No

If yes, enter date of eligibility:	Patient's Social Security Number:

SECTION 5 – CERTIFICATION

Caution: Any person who knowingly and with intent to defraud any insurance company, benefits administrator, or other entity: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals information concerning any material fact for the purpose of misleading, commits a fraudulent insurance act.

I certify that the information I provided on this form is true and complete.

____ ___________________________

(Signature) (Date)

SECTION 6 – CLAIMS BENEFIT ASSIGNMENT

Sign here if you want to receive payment; otherwise, payment will be given to the provider of care.

____ ___________________________

(Signature) (Date)

SECTION 7 – AUTHORIZATION TO RELEASE INFORMATION

I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.

____ ___________________________

(Signature) (Date)

Please include copies of receipts for each claim and documentation from your provider showing procedure and diagnosis codes.

CONFIDENTIAL

This document contains sensitive information that is confidential to the addressee and should not be copied, distributed or reproduced in whole or in part.