MEDICAL CLAIM FORM

Mail Completed Form and Itemized Bill(s) To:
Claims Department
P.O. Box 660303
Dallas, TX 75266-0303

Medical Claim Form

PATIENT INFORMATION

Employer's Name:		Group #:
Employee's Name		Social Security No.:
Date of Birth:	Sex: Male __ Female__	Marital Status: Single __ Married__ Divorced __ Widowed __
Current Mailing Address:		
City: State: Zip:		Telephone:

Spouse's Name: ______________________ DOB: ______________ SS#________________

Name of Employer: ______________________ Telephone: ________________

Employer's Address: ______________________ City: ________________

State: ______________________ Zip Code: ________________

Patient's Name: ______________________ DOB: ________________

Patient's Address: ______________________ City: ________________

State: ____________ Zip: __________ Relationship to Member: ________________

Marital Status: Single __ Married __ Divorced __ Widowed__

If patient is a child age 19, is he/she registered as a full time student in an accredited College or University? Yes __ No __

If "Yes" give complete information:

- Name of College or University: ______________________
- Address: ______________________
- Telephone Number: (____)______________________

Describe the condition, illness or injury (If accident, state where, how, date it occured and if it was work related) ______________________

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COORDINATION OF BENEFITS

OTHER GROUP MEDICAL COVERAGE (This section must be completed)

1. Is the patient eligible for benefits under any other group medical plan? Yes __ No__
2. If the answer to the above is "Yes", please provide:
   a) Name and address of organization providing coverage: ______________________
   b) Policy/Group Number: ______________________
   c) Name and address of location where claims are processed: ______________________

DIRECT PAYMENT

ASSIGNMENTS OF BENEFITS

I hereby authorize payment directly to PLEASE REIMBURSE PATIENT of the medical benefits due under this group policy, not to exceed the eligible charges submitted. I understand I am financially liable for charges not covered by this authorization. This assignment is valid only for the expense(s) accompanying this form and the Assignee indicated.

Employee Signature: DO NOT SIGN HERE Date: ________________

AUTHORIZATION

TO BE COMPLETED BY PATIENT – AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE the disclosure of relevant information about me for the purpose of evaluation and administering my claim.

I AUTHORIZE the following to disclose such information any physical, medical, professional, hospital, clinic other medical or medically related facility, insurance or reinsurance company, consumer reporting agency, medical or hospital service, prepaid health plan, employer, group policy holder, or benefit plan administrator. They may disclose such information to Memorial Hermann Health Insurance Company its reinsurers, consumer reporting agency, attorney, agent or independent administrator action on his behalf.

I UNDERSTAND that relevant information for claims purposes includes employment related information about medical care, advice, diagnosis, treatment, supplies provided, mental illness, and drug or alcohol use.

I UNDERSTAND that Memorial Hermann Health Insurance Company will not release the information EXCEPT to reinsuring companies, to other persons or organizations, performing businesses or legal services in connection with my claim or as the law otherwise requires or permits.

I KNOW THAT I MAY RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that the Authorization shall be valid as follows: **a)** For Claims of Health Insurance Benefits for one year from the date shown below or for the term of coverage of the policy, whichever is shorter, or **b)** For all other claims, for one year from the date shown below for the duration of the claim, whichever is shorter.

I WARRANT that the information furnished on this claim form is accurate and complete and that providing false or misleading information is illegal.

Signature: X ______________________ Date: ________________
Employee

Patient Signature – If not minor: ______________________ Date: ________________