PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

MEDICAL MUTUAL OF OHIO®

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐ PICA ☐☐☐

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (VA File #1)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN or ID)	OTHER ☐ (ID)	1a. INSURED'S ID 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 (Street No.)			6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐				7. INSURED'S ADDRESS (Street No.)
CITY	STATE		8. PATIENT STATUS Spouse ☐ Married ☐ Other ☐				CITY / STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )		Employed ☐ Full-Time Student ☐ Part-Time Student ☐				ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO				a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐			b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO				b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? ☐ YES ☐ NO				c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. ID NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE) 1. ____ 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX ID NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#		

PLEASE PRINT OR TYPE

ATTENTION PROVIDER — FOR FASTER CLAIM PROCESSING REMEMBER:

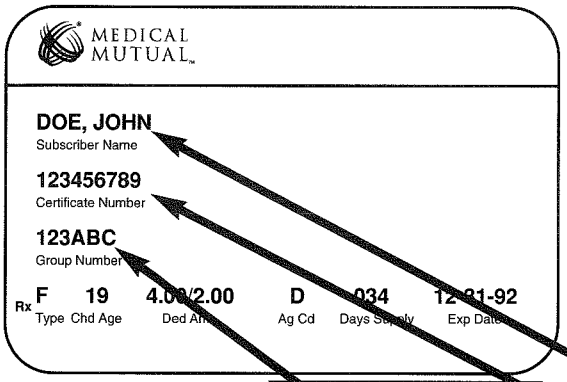
- The Insured's certificate number (Item #1a) is critical to the timely and accurate processing of this claim. Remember to include any Alphabetic characters which may precede the certificate number.
- The patient's birth date must be listed. (Item #3)
- The insured's full address and zip code are required. (Item #7)
- Onset date must be completed. (Item #14)
- Diagnosis codes (Items #21 and 24E) and procedure codes (Item #24D) are required.
- The Provider/Supplier SSN or Tax ID # must be completed. (Item #25 or 33)
- SUPER BILLS SLOW DOWN CLAIM PROCESSING.
- ELECTRONIC CLAIMS SUBMISSION SPEEDS CLAIMS PAYMENT.

PLACE OF SERVICE CODES:

41 – Ambulance
42 – Ambulance-Air/Water
24 – Ambulatory Surgical Center
25 – Birthing Center
53 – Community Mental Health Center
61 – Comprehensive Inpatient Rehab. Facility
62 – Comprehensive Outpatient Rehab. Facility
33 – Custodial Care
52 – Day Care/Psy. Part. Hosp.
11 – Doctor's Office
23 – Emergency Room Hospital
34 – Hospice
65 – Independent Kidney Disease Treatment Center
81 – Independent Laboratory
21 – Inpatient Hospital
51 – Inpatient Psych. Facility
26 – Military Treatment Facility
32 – Nursing Care
99 – Other Locations
22 – Outpatient Hospital
12 – Patient's Home
56 – Residential Treatment Center
72 – Rural Health Clinic
31 – Skilled Nursing Facility
54 – Specialized/Intermed./Mental TC
71 – State or Local Public Health Clinic

TYPE OF SERVICE CODES:

1 – Medical Care
2 – Surgery
3 – Consultation (Inpatient only)
4 – Diagnostic X-Ray
5 – Diagnostic Laboratory
6 – Radiation Therapy
7 – Anesthesia
8 – Assistant at Surgery
9 – Other Medical Service
0 – Blood or Packed Red Cells
A – Used DME
C – Inpatient Psychiatric Services
F – Ambulatory Surgical Center
G – Purchased DME
H – Hospice
H – Rental DME
L – Renal Supplies in the Home
M – Alternate Payment for Maintenance Dialysis
M – Vision Care
N – Kidney Donor
V – Pneumococcal Vaccine
V – Hearing Care
Y – Second Opinion on Elective Surgery
Z – Third Opinion on Elective Surgery



ALL Claims should be forwarded to:

Medical Mutual
P.O. Box 6018
Cleveland, OH 44101-1018

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Your healthcare partner since 1934

HEALTH INSURANCE CLAIM FORM

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CITY / STATE	8. PATIENT STATUS Spouse ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

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PATIENT CLAIM FILING INSTRUCTIONS INFORMATION

1. Use this form for filing claims for reimbursement of all eligible Medical and other expenses eligible under MM insurance programs.
2. Complete all Items #1-10 and 12 and 13 contained in the Patient and Insured Information section, including your signature and date. All the information is essential for prompt and accurate processing of your claim(s).
3. If you are submitting the claim, you must either have the provider (physician) of the services complete the Physician/Supplier Information section of this form, or submit an itemized statement (which should include the information noted).
4. The form must include name of patient, date(s) of service, type of service(s) performed, diagnosis, charge(s) and date(s) symptom first appeared.
5. If the Hospital, Physician or other Health Care Provider is submitting the claim, the Provider/Supplier should complete Items #14-33.
6. If you are submitting a drug claim, be sure to include the prescription drug number and drug name, date of purchase, prescribing doctor and amount charged.
7. Balance due statements cannot be processed and will be returned. We need itemized statements for faster processing and better service.
8. Onset date is required (Item #14), otherwise the claim will be returned.
9. To ensure receipt of your EOB and/or reimbursement, please indicate if there is a change in the insured's mailing address. (Item #7)

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

WARNING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. (Indiana Code IC 27-2-16-3)