How to Complete This Medical Claim Form

Please complete this form properly and in its entirety. To avoid delays in processing, be sure to attach an original fully itemized bill(s) along with any supporting documentation.

1. The Member or Authorized Person must complete the following sections of the Benefit Claim Form:

- Member
- Patient Information
- Accident Information
- Medicare Information
- Other Health Insurance
- Authorization/Release of Information/Assignment of Benefits

2. Authorization/Release of Information

Your signature authorizes the Plan to obtain information to carry out our processing of the claim(s).

3. Assignment of Benefits

Your signature authorizes the Plan to pay the Provider or Supplier directly.

4. Submitting the Claim Form

Please check with the Provider or Supplier to see if they will file the claim on your behalf, especially if MHBP is the secondary payer. Otherwise, you are responsible for the filing of the claim(s) with us.

If you have an itemized bill, please attach and mail to the address on the claim form. If you need assistance with completing this form, please contact the Plan at **1-800-410-7778**.

Medical Claim Form

P.O. Box 8402
London, KY 40742

MHBP SM

Member Information *(please print)*	See Page 1 for instructions on how to complete this claim form.		
Last Name	First	MI	Member ID Number

Patient Information – Complete this section only if claim is for a qualified dependent.			
Last Name	First		MI
Patient ID	Date of Birth	Relationship	Sex

Accident Information – Complete this section only if claim is result of accident or work-related illness or injury.		
Date of accident or first symptoms of illness?	Where did the accident occur? (City/State)	Is accident/illness related to employment? If no, ☐ Auto ☐ Other
Describe the accident or illness.	Give date patient first consulted physician.	Has patient ever had same or similar symptoms? ☐ Yes ☐ No

Medicare Information – Complete this section only if patient is eligible for Medicare.			
Please attach copy of the "Explanation of Benefits" statement from your Medicare insurance carrier.	Medicare Number (include any alpha characters)	Effective Date Part A	Effective Date Part B

Other Health Insurance – If Yes, complete section below or claim cannot be processed. ☐ No other coverage			
Name of Policyholder	Policy Number	Name of Insurance Company/Phone Number	
Street Address	City	State	ZIP

Authorization/Release of Information

I authorize any insurance company, organization, employer, hospital physician, pharmacist or other health care provider to release any information requested with regard to this claim and the expenses reported. I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to omit facts I know are important.

Patient or authorized person's signature _____ **Date** _____

Assignment of Benefits

I agree to assign benefits directly to the provider of services: _____ **Date** _____

Patient or authorized person's signature

THIS SECTION FOR PHYSICIAN OR SUPPLIER ONLY.

If a detailed statement is available, please attach.

Provider Statement of Services Rendered

Name and address of facility where services were rendered (if other than home or office)	Date Admitted	Date Discharged

Diagnosis Code and Description

1. 3.
2. 4.

Date of Service (from/to)	Place of Service	CPT-4 Procedure Code	Description of Service	Charges	Days or Units	
Signature of Provider				Total Charge	Amount Paid	Balance Due

Provider Name	Tax ID Number
Provider Address	Telephone Number ( )