HealthNow Administrative Services

Medical Claim Form

Instructions for Filing a Claim

A. COMPLETE EMPLOYEE'S STATEMENT. Please be sure to answer every question.

B. Complete "Authorization to Release Information" for hospital, physician's or dentist's statement.

C. All bills must show patient's name, date(s) of treatment, nature of treatment (diagnosis), fee for each service and the tax identification number of the provider. The hospital, doctor or other provider may forward claims directly to the address shown below or to the employee.

D. If you wish payment made directly to the hospital or doctor, complete the appropriate "Authorization to Pay Benefits".

E. MAIL COMPLETED FORM TO: HealthNow Administrative Services, P.O. Box 211034, Eagan, MN 55121. Phone: 1-855-581-1809.

When submitting an itemized bill, please retain a copy for your records.

Employee's Statement of Claim for Group Health Benefits

I HEREBY PRESENT THIS CLAIM, and authorize any individual or organization to release information required for its acceptance.

1 CLAIM IS BEING MADE FOR: ☐ Self ☐ Spouse ☐ Child

2 Patient's Name	Date of Birth	Sex

3 Is claim due to auto accident? ☐ Yes ☐ No	Other accident or injury? ☐ Yes ☐ No	Date and place of accident or injury

Describe accident: (Indicate name of state where accident occurred or provide brief description of incident)

4 Is this claim the result of a work related illness or injury? ☐ Yes ☐ No

5 Are you (employee) married? ☐ Yes ☐ No

Is your spouse employed? ☐ Yes ☐ No

Name of Spouse

Employer

Address

5a If claim is for a dependent child, is the child employed? ☐ Yes ☐ No

Employer

Address

6 If patient is spouse or dependent, are they also covered by any of the following: ☐ Yes ☐ No

If yes, check box below which applies and complete 6a.

☐ Group health benefits of any kind.

☐ Coverage of medical care expenses provided by an employer or union welfare plan, any federal state provincial or other government program.

☐ Other arrangement of benefits, for individuals of a group

6a Give name, address and telephone number of other company or organization providing benefits

Name

Address

7 Employee's Name (Please Print)	Employee's Signature	Social Security Number

Address	City	State	Zip Code	Date

8 Employee's Birthdate	Spouse's Birthdate

PATIENT AUTHORIZATION

AUTHORIZATION FOR USE IN CLAIMING GROUP BENEFITS

To all physicians and other medical professionals, hospitals and other medical-care institutions and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators.

You are authorized to provide HealthNow Administrative Services and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on HealthNow Administrative Services' behalf, with information concerning medical care, advice, treatment or supplies provided the patient and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administering claims for benefits.

I understand that the duration of the authorization is for the term of coverage of the plan under which a claim for health benefits has been submitted.

I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

DATE _____ PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: _____

RELATIONSHIP OF AUTHORIZED PERSON: _____

AUTHORIZATION TO PAY HOSPITAL/PHYSICIAN

I hereby authorize payment directly to the below named hospital and/or physician otherwise payable to me for services described below. I understand I am financially responsible for the hospital medical and/or physician charges not covered by this authorization.

DATE: _____ EMPLOYEE SIGNATURE: _____