COUPE HEALTH

MEDICAL EXPENSE CLAIM

FILL OUT A SEPARATE FORM FOR EACH PATIENT.
Use this form to file a claim for any eligible medical expenses when your physician or other provider does not file a claim.
Please **print** clearly with black ink or **type.**

1. Patient's Name (only one Patient per form)

Last First Middle Initial

2. Contract Number as shown on your I.D. Card
(include any letters, if applicable)

3. Group Number (as shown on I.D. Card) or Place of employment

4. Patient's Date of Birth mm dd yyyy

5. Patient's Sex ☐ **Male** ☐ **Female**

6. Patient's Relationship to Contract Holder
☐ **Self** ☐ **Child** ☐ **Spouse** ☐ **Other** (explain)

7. Contract Holder Information (name as shown on your I.D. card)

Last First Middle Initial

Street

City State Zip

( ) Daytime telephone number and extension

8. Is patient covered under any other group health insurance plan?
☐ YES ☐ NO If **yes,** complete the following:

Name of Policy Holder
Last First Middle Initial

Name and Address of Insuring Company **I.D. Number**

Is the patient entitled to Medicare benefits? **Policy Effective Date** mm dd yyyy

Part A ☐ YES ☐ NO ☐ Part B ☐ YES ☐ NO **Medicare Number**

9. Was condition related to:
a. Patient's Employment ☐ **YES** ☐ **NO**
b. Auto Accident ☐ **YES** ☐ **NO**
c. Other Accident/Injury ☐ **YES** ☐ **NO**

(If **yes**,give date of accident or onset of illness): mm dd yyyy

10. Diagnoses (type of illness or injury)

11. Ordering Physician
Phone ( )
Last Name First Name
Address City State Zip

INSTRUCTIONS: Attach the original bill or statement from the physician or supplier and **keep a copy for your records. Make sure the bill contains all required information** (see back of form for required information). **Sign this form.**

I, the undersigned, furnished the above information to enable Coupe Health to consider this claim for payment, and I certify that such information is true and correct and that the expenses were incurred by the above named patient.
I understand that any payment will be made to me.

Signature Date

SEE BACK OF CLAIM FORM FOR EASY CLAIM FILING INSTRUCTIONS

FILING YOUR CLAIM IS EASY

1. Fill out the Medical Expense Claim form (include all requested information).

2. Attach the bill (or clear copy of the bill) to this form.

Your bill should include the following information: (do not attach a balance forward bill)

- Patient's full name.
- Date of treatment.
- A description of the treatment provided (i. e. office visit, x-ray, surgery etc.)
- A diagnosis (type of illness or injury).
- Charge for each treatment.
- Place of treatment (i.e. doctor's office, hospital, one day surgery clinic, etc.)
- Date of accident (if applicable).
- Any Medical Equipment and/or supplies purchased. (Supply the invoice and be sure to complete box 11, Ordering Physician, on the front of this form.)

Note: The above information is usually provided on an itemized bill from the provider.)

THIS INFORMATION IS NEEDED TO PROPERLY FILE PRESCRIPTION DRUG CLAIMS.

Attach the receipt or legible copy of receipt given by the pharmacist. The receipt should list the following information:

- The patient's name.
- The National Drug Code (NDC).
- The name of the prescription drug and manufacturer.
- The amount of the prescription drug.
- The name of the Pharmacy along with the telephone number and address.
- The name of the Doctor that prescribed the drug.
- Please indicate on the receipt the reason for taking each prescription.

Members can mail the completed claim to:		Members can also fax claims to:
Birmingham Service Center **Claims Department** **Post Office Box 10527** **Birmingham, Alabama 35202-0500**	**OR**	**205-220-2146** **800-526-8529**