THIS SIDE TO BE COMPLETED BY ATTENDING PHYSICIAN OR PROVIDER

INSTRUCTIONS

1. List procedures, medical service and/or supplies for: Surgery • Doctors Visits • Hospital Confinement • Mental Illness Expenses
2. Include CPT-4 procedure, ICD-9 diagnosis, place of service, type of service and specialty codes for each service provided or as required.
3. IF ASSIGNED BENEFITS (Benefits are automatically assigned to the physician for patients with HMO coverage):
   - Send completed claim form and itemized bills to appropriate claims office address as shown on the back of attached envelope.
   - Itemized bills should include: Employee Name • Date and Type of Service • Charge for Service • Patient Name • Diagnosis.
   - Drug bills must be originals (No Xerox) and include: Patient and Physician Names • Charge Amount • Prescription Number and Date • Drug Name
   - Be certain to include the Physician's or Provider's Federal Tax Identification Number.

The claim WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

1 Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	2 Date first consulted you for this condition	3 If Patient has had same or similar illness or injury, give dates	4 If Emergency, Check here ▶ ☐
5 Date Patient able to return to work	6 Dates of Total Disability From / Through	7 Dates of Partial Disability From / Through	
8 Name and Phone Number of Referring Physician or other Source (e.g., Public Health Agency)		9 For services related to Hospitalization, give Hospitalization dates Admitted / Discharged	
10 Name and Address of Facility where services rendered (if other than home or office)		11 Was Lab Work performed outside your office? ☐ YES ☐ NO Charges:	12 Authorization No.
13 Principal Diagnosis - 1	14 ICD-9-CM Code ▲	15 Additional Diagnosis - 2	16 ICD-9-CM Code ▲
17 Additional Diagnosis - 3	18 ICD-9-CM Code ▲	19 Additional Diagnosis - 4	20 ICD-9-CM Code ▲

RELATE DIAGNOSIS TO PROCEDURE IN DIAGNOSIS CODE COLUMN BY REFERENCE NUMBERS 1, 2, 3, 4

21 SERVICE DATES FROM	TO	* POS	CPT-4 CODE	MODIFIER	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	DIAGNOSIS CODE	UNIT CHARGES	DAYS OR UNITS	** TOS	TOTAL CHARGES
						▲	▲			▲
						▲	▲			▲
						▲	▲			▲
						▲	▲			▲
						▲	▲			▲
						▲	▲			▲

22 Signature of Physician or Supplier (including Degree(s) or Credential(s)) I certify that the services were provided by me and were medically necessary.	23 Total Charge	24 Amount Paid	25 Balance Due

26 Physician's, Supplier's, and/or Group Name, Address, Zip Code, Telephone No. and I.D. No.

27 Your Social Security No.	28 Your Patient's Account No.	29 Your Employer I.D. No.	*** SC

*PLACE OF SERVICE CODES

1 - Inpatient Hospital (H)
2 - Outpatient Hospital (OH)
3 - Doctor's Office (O)
4 - Patient's Home (H)
5 - Day Care Facility (PSY)
6 - Night Care Facility (PSY)
7 - Nursing Home (NH)
8 - Skilled Nursing Facility (SNF)
9 - Ambulance
0 - Other Locations (OL)
A - Independent Laboratory (IL)
B - Other Medical/Surgical Facility
C - Residential Treatment Center (RTC)
D - Specialized Treatment Center (STF)

**TYPE OF SERVICE CODES

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

***SPECIALTY CODES

AI - Allergy and Immunology
AN - Anesthesiology
CD - Cardiovascular Diseases
DC - Chiropractic Services
D - Dermatology
EM - Emergency Medicine
END - Endocrinology
FP - Family Practice
GE - Gastroenterology
GP - General Practice
GER - Geriatrics
HEM - Hematology
ID - Infectious Diseases
IM - Internal Medicine
MFS - Maxillofacial Surgery
NEP - Nephrology
N - Neurology
NPM - Neonatal-Perinatal Medicine
NM - Nuclear Medicine
OBG - Obstetrics/Gynecology
ON - Oncology
OPH - Opthalmology
OTO - Otorhinolaryngology
PTH - Pathology
PD - Pediatrics
PM - Physical Medicine and Rehabilitation
DPM - Podiatry
P - Psychiatry
PUD - Pulmonary Diseases
R - Radiology
TR - Radiology, Therapeutic
CDS - Surgery, Cardiovascular
GS - Surgery, General
NS - Surgery, Neurological
ORS - Surgery, Orthopedic
PS - Surgery, Plastic
TS - Surgery, Thoracic
U - Surgery, Urological
OS - Other

HEALTH CARE BENEFITS CLAIM FORM

THIS SIDE TO BE COMPLETED BY EMPLOYEE
(Reverse side to be completed by Provider)

[illegible] WITH THE HUMANA FAMILY [illegible] INSURANCE AND [illegible] PLAN COMPANIES

INSTRUCTIONS
1. [illegible]
2. [illegible]
3. [illegible] ARE NOT acceptable.
4. [illegible] provider of service [illegible] confirmation will be [illegible]

☐ Check here if covered through COBRA continuation provision.

1 Employee's Name (Last) (First) (M.I.)	2 Social Security Number (I.D. Number)	3 Group Number (First 6 digits)
4 Employee's Home Address	5 Group Name (if Humana Inc. employee, facility where employed)	
	6 Employee's Employment Status ☐ Active ☐ Retired ☐ Disabled	7 Date of Retirement or Disability / 8 Employee's Birth Date
9 Patient's Name (Last) (First) (M.I.)	10 Patient's Relationship to Employee ☐ SELF ☐ SPOUSE ☐ OTHER ____	

11 Patient's Birth Date	12 Patient's Employment Status ☐ Active (If so, where employed: ____ ☐ Retired ____ ☐ Disabled ____)	CHILD ▷ ☐ UNDER 19 ☐ HANDICAPPED ☐ FULL - TIME STUDENT ☐ PART - TIME STUDENT ☐ SINGLE ☐ MARRIED ▷	Expected Date of Graduation
13 Patient's Sex ☐ M ☐ F			Name of School

14 Is Patient covered by other group health plan? ☐ YES ☐ NO	15 Name and Address of Other Carrier	17 Is your spouse employed? ☐ YES ☐ NO	18 Name, Address and Telephone of Spouse's Employer
16 Plan/Policy Number		19 Spouse's Birth Date	
		Social Security Number	

IF CLAIM IS ACCIDENT-RELATED, COMPLETE THIS SECTION

20 Accident Date	21 Accident Time	29 Did the accident involve a motor vehicle? ☐ YES ☐ NO	30 Name and Address of Your Vehicle Insurance Carrier
22 Did the accident occur while on the job? ☐ YES ☐ NO			
23 Did the accident occur on another person's premises? ☐ YES ☐ NO	24 Name and Address of Person on Whose Premises the Accident Occurred	31 Did you file a claim with your vehicle insurance carrier? ☐ YES ☐ NO (If YES, attach a copy of the claim submitted)	32 Name and Address of Other Vehicle Owner Involved
25 Did accident occur while using a product or item? ☐ YES ☐ NO	26 Name of Product or Item / 27 Place of Purchase	33 Was a police report made? ☐ YES ☐ NO	34 Name and Address of Other Vehicle Owner's Insurance Carrier
28 Do you believe another party was responsible for or caused the accident? ☐ YES ☐ NO			

RELEASE OF INFORMATION

I authorize the release of any medical information [illegible] understand that, as permitted by law, to the extent of [illegible] claim, the Plan acquires all rights of recovery I may have against [illegible] responsible for these expenses.

35 Patient or Authorized Person's Signature	Date

IF PAYMENT IS TO BE SENT DIRECTLY TO PROVIDER

[illegible] directly to the provider of services and I understand that I am financially responsible for the hospital, medical or physician charges not covered by this authorization.

36 Employee's Signature	Date

▶ ***Any person who knowingly causes to be prepared or who presents a false or fraudulent claim to an insurer for the payment of a loss is guilty of the crime of insurance fraud and may be subject to fines and confinement in a state prison, among other things.***

HU-0994 7/02