

Health Benefits Claim Form

To Be Completed By Member

For use with the Humana Family of Health Insurance and Health Plan Companies

INSTRUCTIONS	<p>1. Complete ALL information requested below.</p> <p>2. Use separate form for each family member and for each accident or illness.</p> <p>3. Enclose ORIGINAL itemized bills. Please keep a copy for your records. Cancelled checks ARE NOT acceptable.</p> <p>4. ASSIGNMENT: If you wish benefits to be paid directly to the physician or provider of service, sign the Direct Payment block below. NOTE: Benefits for hospital confinement will be paid directly to the hospital.</p> <p>5. Mail completed form to the address on the back of your insurance card.</p>
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1. Employee/Member Name (Last) (First) (M.I.)	2. Member ID (11 characters):	3. Group Number
4. Employee/Member Home Address	5. Group Name	
	6. Employee/Member Birth Date:	7. Patient Birth Date:
8. Patient's Name (Last) (First) (M.I.)	9. Patient's Relationship to Employee:	

10. Service Dates		Place of Service*	CPT Code/Service Description	Diagnosis Code	Unit Charges	Days or Units	Total Charges
From	To						

- | *Place of Service Codes |
|---|
| <ul style="list-style-type: none"> 11- Doctor's Office 12- Patient's Home 20- Urgent Care 21- Inpatient Hospital 22- Outpatient Hospital 23- Emergency Room 31- Skilled Nursing Facility 32- Nursing Home 33- Other Medical/Surgical Facility 41- Ambulance 52- Psychiatric Facility 55- Residential Treatment Center 72- Rural Health Clinic 81- Independent Laboratory 99- Other Locations |

11. Physician, Supplier and/or Group Name Address, Zip Code, Telephone No. and Tax ID No.

RELEASE OF INFORMATION	If Payment Is To Be Sent Directly To Provider								
<p>I authorize the release of any medical information necessary to process this claim. I understand that, as permitted by law, to the extent of benefits paid under this claim, the Plan acquires all rights of recovery I may have against other parties considered responsible for these expenses.</p>	<p>I hereby authorize payment 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.</p>								
<table border="1"> <tr> <td>12. Patient or Authorized Person's Signature</td> <td>Date</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>	12. Patient or Authorized Person's Signature	Date			<table border="1"> <tr> <td>13. Employee's Signature</td> <td>Date</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>	13. Employee's Signature	Date		
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Any person who knowingly and with intent to defraud any insurance company and files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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