OhioHealthy

# Medical Claim Form

**OhioHealthy Claims**
**PO Box 4278**
**Clinton, IA 52733 -4278**
**FAX: 877.411.5964**

## INSTRUCTIONS:

1. Please complete all sections
2. All itemized bills MUST be attached and include: Patient's name, Provider's name, diagnosis, dates of services and charge amount.
3. If you or a dependent are covered by another Plan (including Medicare), please submit the bill to the Primary Plan first. Then send our office a copy of the Explanation of Benefits along with the bill.

## EMPLOYEE INFORMATION

| Name (First, Middle, Last) | Sex ☐ Male ☐ Female | Birthdate | Member Number |
|---|---|---|---|
| | | | |

| Home Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Employer | Date of Hire | Occupation | Date Last Worked |
|---|---|---|---|
| | | | |

## PATIENT INFORMATION

| Patient Name (First, Middle, Last) | Relationship | Sex ☐ Male ☐ Female | Birthdate |
|---|---|---|---|
| | | | |

| Is the patient married? ☐ Yes ☐ No | Is the Patient a Full-time Student? ☐ Yes ☐ No | If yes, How Many Hours? | Date Last Attended? | Name and Address of School |
|---|---|---|---|---|
| | | | | |

| Nature of Illness | Name, Address and Phone No. of Doctor Seen For This Illness |
|---|---|
| | |

## IF CLAIM IS BASED ON AN ACCIDENT, COMPLETE THE FOLLOWING

| Date and Time of Accident | Was Accident Work Related? ☐ Yes ☐ No | Place | How it Happened |
|---|---|---|---|
| | | | |

## SPOUSE INFORMATION

| Name (First Middle, Last) | Sex ☐ Male ☐ Female | Birthdate | Soc. Sec. No. |
|---|---|---|---|
| | | | |

| Spouse's Employer Name and Address | Phone No. |
|---|---|
| | |

## OTHER INSURANCE INFORMATION

| Do You or Your Dependents Have Other Coverage? ☐ Yes ☐ No | Type of Coverage? ☐ Single ☐ Family | Type of Plan? ☐ Group Health Plan ☐ Government Plan ☐ Medicare ☐ Other |
|---|---|---|
| | | |

| Name of Person Covered by Other Insurance | Group Number | Soc. Sec. No. | Benefits ☐ Medical ☐ Dental ☐ Vision ☐ Other |
|---|---|---|---|
| | | | |

| Name and Address and Phone No. of Other Insurance Company |
|---|
| |

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AUTHORIZATION TO RELEASE INFORMATION --

I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to Luminare Health for any oral or dental observation, treatment, services, or benefits rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

PATIENT'S SIGNATURE (PARENT IF MINOR)

DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS --

I hereby authorize payment of benefits to any providers of service rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

PATIENT'S SIGNATURE (PARENT IF MINOR)

DATE



3430 OhioHealth Parkway
Columbus, OH 43202

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