Medical Claim Request Form

To be completed by Member Patient and Provider
Mail completed form and supporting documentation to:

Contigo Health, LLC
P.O. Box 2582
Hudson, Ohio 44236-2582
Fax to: 1-877-885-0650

PART I PRIMARY MEMBER AND PATIENT INFORMATION

(please print or type)

1. IDENTIFICATION NUMBER	2. GROUP NUMBER	3. PATIENT NAME (Last, First, Initial)	4. PATIENT BIRTHDATE MONTH / DAY / YEAR
5. PATIENT SEX ☐ MALE ☐ FEMALE	6. PATIENT RELATIONSHIP TO PRIMARY MEMBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER		7. PRIMARY MEMBER NAME (Last, First, Initial)
8. PRIMARY MEMBER ADDRESS (Street, City, State, Zip Code)			

COORDINATION OF BENEFITS INFORMATION - ANSWER "YES" OR "NO" TO ALL QUESTIONS

9. IF NO, GO TO QUESTION 10. WERE THESE SERVICES REQUIRED AS A RESULT OF A JOB-RELATED ILLNESS OR ACCIDENT? ☐ YES ☐ NO	9a. NAME AND ADDRESS OF EMPLOYER	9b. NAME AND ADDRESS OF COMPENSATION CARRIER	9c. DATE OF ACCIDENT
10. IF NO, GO TO QUESTION 11. WERE SERVICES REQUIRED FOR A CONDITION RESULTING FROM AN ACCIDENT OR INJURY CAUSED BY ANOTHER PARTY? ☐ YES ☐ NO			10b. DATE OF ACCIDENT OR INJURY
11. IF NO, GO TO QUESTION 12. IS PATIENT COVERED BY ANY OTHER GROUP HEALTH BENEFIT PLAN? ☐ YES ☐ NO	11a. NAME OF POLICY HOLDER	11b. NAME AND ADDRESS OF INSURANCE COMPANY	11c. POLICY HOLDER
12. IF NO, GO TO QUESTION 13. WERE SERVICES REQUIRED DUE TO AN AUTOMOBILE ACCIDENT? ☐ YES ☐ NO	12a. NAME AND ADDRESS OF AUTOMOBILE INSURANCE COMPANY		12b. DATE OF ACCIDENT
13. IF NO, GO TO QUESTION 14. IS PATIENT ELIGIBLE FOR PART A AND/OR PART B MEDICARE?	PART A ☐ YES ☐ NO PART B ☐ YES ☐ NO		13b. MEDICARE NUMBER
PATIENT (OR PRIMARY MEMBER IF PATIENT IS A MINOR) SIGNATURE:			DATE

PART II PHYSICIAN, PROVIDER, OR SUPPLIER INFORMATION *(to be completed by physician/provider/supplier only)*

14. DIAGNOSIS OF ILLNESS OR INJURY (include ICD code)	
15. NAME OF PHYSICAN/PROVIDER/SUPPLIER WITH TAX ID# TIN #	16. IF PLACE OF SERVICE WAS OUTPATIENT HOSPITAL, PROVIDE NAME OF HOSPITAL FACILITY
17. IF WE HAVE QUESTIONS, WHO MAY WE CONTACT? NAME PHONE NUMBER	

PLEASE COMPLETE THE FOLLOWING AS A SUMMARY OF THE ITEMIZED BILLS YOU HAVE ATTACHED TO THIS CLAIM FORM

18. DATE OF SERVICE	19. PLACE OF SERVICE	20. CHARGE FOR SERVICE	21. DESCRIBE SERVICE RECEIVED (include CPT code)
22. TOTAL CHARGES FOR WHICH YOU ARE REQUESTING CONSIDERATION OF PAYMENT		$.	PLACE OF SERVICE KEY IP - INPATIENT HOSPITAL O - OFFICE OP - OUTPATIENT HOSPITAL OL-OTHER H - HOME NH - NURSING HOME L - LAB
23. I CERTIFY TO THE ACCURACY AND COMPLETENESS OF ALL INFORMATION REPORTED BY ME ON THIS FORM AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. PHYSICIAN/PROVIDER/SUPPLIER SIGNATURE:			**DATE:**

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COMPLETION OF THE MEDICAL CLAIM REQUEST FORM

Patient/Covered Member Instructions

1. Each time benefits are requested, complete the first section (items 1 through 13) on the Medical Claim Request form. Each covered member/dependent reimbursement request requires a separate Medical Claim Request Form.

2. Please have your physician or provider (or supplier in the event of medical supplies) complete Part II (items 14 through 23) of the Medical Claim Request Form or attach an itemized bill(s).

   Itemized bills should include: provider's name; patient's name; date of service; condition being treated; CPT code(s), total charge for the service, and the provider/supplier/hospital billing address with zip code.

3. If the patient is eligible for Medicare, you must include the statement(s) of payment or rejection from Medicare, part A and Part B.

4. If the patient has primary coverage with another Group Plan, you must include the primary carrier's statement of payment or rejection of the claim.

5. Documentation of your payment must be submitted with the Medical Claim Request Form.

6. Prior to submission, please review the Medical Claim Request Form to verify that all fields have been completed and that the patient (or Primary Member if the patient is a minor) has signed and dated the form. An incomplete Medical Claim Request form and insufficient supporting documentation may lead to delays in claims processing and a denial of the claimed benefit.

Physician, Hospital or Supplier Instructions

Complete Part II, items 14 though 23, on the Medical Claim Request Form using current CPT procedure and ICD diagnosis codes.

Please provide an itemized bill which includes: provider's name; patient's name; date of service; condition being treated; CPT code(s), total charge for the service and the provider/supplier/hospital billing address with zip code.

Member Instruction for Medical Claim Form and Supporting Documentation Submission

Mail the completed form and supporting documentation to:

Contigo Health, LLC
PO Box 2582
Hudson, Ohio 44236-2582

Fax the completed form and supporting documentation to: 1-877-885-0650. If you have any questions regarding this form, please call the number listed on the back of your Member ID Card.

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