SummaCare℠

Claim Form for Medical Benefits

TO BE COMPLETED BY THE MEMBER

1. Member's Name _____ **Date of Birth** _____
First Middle Last

2. Member's Home Address _____

3. Member's City _____ **State** _____ **Zip** _____

4. Member Number _____ **Telephone No.** (_____)_____-_____

5. Are any of your dependents including your spouse presently employed? ☐ **Yes** ☐ **No**

Name	Social Security Number	Relationship	Name/Address of Employer (Including Zip Code and Phone No.)

6. Are any medical, dental or pharmacy expenses covered under another employer group, union, welfare plan school, or program?

☐ **No** ☐ **Yes - if "Yes", complete the following:**

Name and address of company or organization (i.e., employer, union, association, etc…) sponsoring the plan or program

_____

_____

Name and address of insurance carrier _____

_____

Policy Number _____

7. If any of the expenses included o the claim are covered under Medicare, complete the following:

Is the patient covered under MEDICARE Hospital insurance Part A ☐ **YES** ☐ **NO Eff. Date** _____**/Mo.**_____**/Day** ____**/Year**

Is the patient covered under MEIDCARE Hospital insurance Part B ☐ **YES** ☐ **NO Eff. Date** _____**/Mo.**_____**/Day** ____**/Year**

8. If expenses on this claim are for medical services for an eligible dependent, answer the following:

Dependent's Name _____
First Middle Last

Date of Birth Mo. _____/Day _____/Year_____ **Sex:** ☐ Male ☐ Female

Relationship to Employee: ☐ Spouse ☐ Child

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any physician, hospital, pharmacy, insurance company, employer, third party payer or organization to release any information regarding the history, treatment, or benefits payable concerning this claim to SummaCare or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim.

I certify that the information submitted by me is true and correct and I understand that falsifying a claim can lead to disciplinary action, including discharge.

Member's Signature _____ Date _____

To Contact SummaCare Customer Service, please refer to the phone number listed on your identification card.

SummaCare℠

Any Person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits fraudulent insurance act which is a crime.

INSTRUCTIONS FOR FILING A CLAIM

Complete the member's section on the reverse side.

- Use a separate claim form for EACH member of the family for each claim submitted
- Complete the Authorization Section above
- All bills for related expenses should be submitted at the same time.

Send completed claim form and itemized bills to:

SummaCare
P.O. Box 3620
Akron, Ohio 44309-3620

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER

Signature _____

Diagnosis or nature of illness or injury – related diagnosis to procedure in column D by reference to numbers 1, 2, 3 etc or diagnosis code.

1.
2.
3.
4.

Date of Service	*Place of Service	Procedures, medical services or supplies furnished for each date given	ICD – 10 Diagnosis	Charges
				$0.00
				$0.00
				$0.00
				$0.00
			TOTAL CHARGES	$0.00

Place of Service Codes:

11 Doctor or Provider's Office		**12 Patient Home**		**21 Inpatient Hospital**		**81 Laboratory**	
23 Emergency Room		**24 Ambulatory Surgery Center**		**41 Ambulance**			
20 Urgent Care Center		**99 Other Location**		**22 Outpatient Hospital**			

Signature of Physician/Provider_____

Physician/Provider Name_____

Provider Address_____

Provider City _____State_____ Zip _____

Physician/Provider Tax ID Number_____Phone_____

Patient's Acct No._____

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