COX HEALTHPLANS
CoxHealth

CLAIM FOR MEDICAL BENEFITS MEMBER FORM

SEE DIRECTIONS ON THE REVERSE SIDE FOR SUBMITTING A CLAIM

SECTION A: (Sections A and E must be completed.)

EMPLOYEE/CONTRACT HOLDER NAME: (FIRST, MIDDLE INITIAL, LAST)	DATE OF BIRTH	SEX: ☐ MALE ☐ FEMALE	EMPLOYEE'S STATUS: ☐ COBRA ☐ ACTIVE ☐ DISABLED
EMPLOYEE/CONTRACT HOLDER ADDRESS: (NO. AND STREET, CITY, STATE, ZIP)			
EMPLOYEE/CONTRACT HOLDER HEALTH INSURANCE ID NUMBER (CLAIM CANNOT BE PROCESSED WITHOUT THIS NUMBER)	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ LEGALLY SEPARATED ☐ DIVORCED ☐ WIDOWED		
IS CLAIM RELATED TO AN ACCIDENT? ☐ YES ☐ NO IF YES, PLEASE COMPLETE **SECTION D** BELOW.	IS THIS CLAIM RELATED TO A WORK ACCIDENT OR ILLNESS? ☐ YES ☐ NO IF YES, PLEASE COMPLETE ***SECTION D*** BELOW.	IS EMPLOYEE/CONTRACT HOLDER COVERED UNDER ANOTHER GROUP HEALTH PLAN? ☐ YES ☐ NO IF YES, COMPLETE ***SECTION C*** BELOW.	

SECTION B: PATIENT INFORMATION (Complete only if patient is other than employee/contract holder.)

PATIENT'S NAME: (FIRST, MIDDLE INITIAL, LAST)	RELATIONSHIP TO EMPLOYEE/CONTRACT HOLDER: Please circle one SPOUSE CHILD OTHER (SPECIFY)	SEX: ☐ MALE ☐ FEMALE	DATE OF BIRTH / /
COMPLETE THIS INFORMATION IF THE PATIENT IS A DEPENDENT CHILD.	IS DEPENDENT COVERED UNDER ANOTHER GROUP HEALTH PLAN? ☐ YES ☐ NO IF YES, COMPLETE ***SECTION C*** BELOW.		

SECTION C: FAMILY/OTHER HEALTH COVERAGE INFORMATION

(Complete if claim is for dependent and/or other coverage is in effect)

IS SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME OF SPOUSE'S EMPLOYER:	TELEPHONE NO. OF SPOUSE'S EMPLOYER:	
ADDRESS OF SPOUSE'S EMPLOYER (NO., STREET , CITY, STATE, ZIP)			
SPOUSE'S DATE OF BIRTH: / /	SPOUSE'S ID / SOCIAL SECURITY NUMBER:	IS PATIENT EMPLOYED? ☐ YES ☐ NO	IS PATIENT COVERED BY ANOTHER GROUP HEALTH PLAN? ☐ YES ☐ NO
NAME OF OTHER COMPANY OR ORGANIZATION PROVIDING BENEFITS:		POLICY PLAN NUMBER:	
ADDRESS OF OTHER BENEFITS CARRIER (NO., STREET , CITY, STATE, ZIP)			

SECTION D: ACCIDENT / WORK-RELATED CLAIM INFORMATION

(Complete if claim is a result of accident or a work-related accident or illness.)

DATE OF ACCIDENT:	NATURE OF ACCIDENT OR WORK RELATED ILLNESS/INJURY:

SECTION E: EMPLOYEE / PATIENT SIGNATURE AND RELEASE (Employee/contract holder must sign all claims.)

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I VERIFY THAT ALL INFORMATION CONTAINED IN THIS FORM IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. IN ORDER TO PROCESS A CLAIM FOR BENEFITS I HEREBY AUTHORIZE ALL INDIVIDUALS OR INSTITUTIONS HAVING INFORMATION AS TO THE CARE, ADVICE, TREATMENT, DIAGNOSIS, OR PROGNOSIS OF ANY PHYSICAL OR MENTAL CONDITION, OR THE FINANCIAL AND EMPLOYMENT STATUS, OR THE PATIENT, EMPLOYEE, OR DECEASED NAMED BELOW, TO PROVIDE THIS INFORMATION TO COX HEALTHPLANS OR ANY AGENT OR INDEPENDENT ADMINISTRATOR ACTING ON ITS BEHALF (INCLUDING RECORDS). I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST. A COPY OF THIS SHALL BE AS VALID AS THE ORIGINAL. THIS AUTHORIZATION IS VALID FOR TWELVE MONTHS FROM THE DATE SIGNED.

PLEASE PRINT NAME OF PATIENT OR DECEASED

SIGNATURE OF MEMBER, AUTHORIZED REPRESENTATIVE, OR NEXT OF KIN DATE

MEMBER SERVICES: (417) 269-2900 OR (800) 205-7665

COX HEALTHPLANS
CoxHealth

CLAIM FOR MEDICAL BENEFITS
MEMBER'S FORM

ITEMS TO REMEMBER WHEN RECEIVING HEALTH CARE SERVICES

Whenever you or your dependents, enrolled under this plan, receive care from a physician, hospital or care from another provider of healthcare services, identify yourself as a Cox HealthPlans member by presenting your identification card. In most situations the providers of service will file the claims for you. If your provider refuses to file the claim, you must file the claim yourself using this claim form. This would include any out-of-network or out-of-area provider.

Please follow the instructions listed below.

FILING CLAIMS

1. Each patient must complete a separate claim form.

2. Each course of treatment or medical case will require an individual claim form.

3. Itemized bills must be included with each completed claim form. Information required on each bill:

   A. Patient's name
   B. Provider's name and address
   C. Date(s) of service
   D. CPT codes or descriptions of services
   E. The charge for each service rendered
   F. Patient's medical diagnosis

   Claims submitted on HCFA forms, Superbills and UB92 forms are all customary and acceptable.

4. There is no limitation to the number of bills attached to each claim form.

5. "Balance due" bills or "professional services rendered" bills are not acceptable.

6. Claims should be submitted by the end of the year in which the services are incurred, if possible. Claims older than one year will not be accepted.

7. When submitting bills for reimbursement, they must be marked paid by the provider's office.

8. If other group health coverage exists, that is primary to this plan, then submit claims to that carrier first. After you have received the primary carrier's explanation of benefit (EOB), send a copy of the EOB with this claim form to Cox HealthPlans for claim consideration.

9. Pharmacy bills for reimbursement must have the pharmacy letterhead or pharmacist's signature, prescription number and drug name. The National Drug Code number is acceptable in lieu of the drug name with the pharmacist's signature. Register receipts or paid receipts are not acceptable.

10. The claim form must be signed and dated by the employee/contractholder.

11. Submit claims to:

Cox HealthPlans
P.O. 5750
Springfield, MO 65801-5750

If you have any questions, comments or need help filing this claim form, please feel free to contact our **Member Services Department at: (417) 269-2900, or out of the area: (800) 205-7665** .