



PIEDMONT COMMUNITY HEALTH PLAN / PIEDMONT COMMUNITY HEALTHCARE

HEALTH BENEFITS CLAIM FORM

Please submit your billing along with this claim form to:
P.O. Box 14408
Cincinnati, OH 45250-0408

Address Change: _____

IMPORTANT: EVERY ITEM MUST BE CHECKED OR ANSWERED BEFORE CLAIM CAN BE PROCESSED

PATIENT	GIVE THE FOLLOWING INFORMATION ABOUT PATIENT			
	1. Claim is made for: <input type="checkbox"/> Husband <input type="checkbox"/> Self <input type="checkbox"/> Wife <input type="checkbox"/> Unmarried <input type="checkbox"/> Other _____ Son/Daughter		2. Patient's Name _____	
			3. Date of Birth _____	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F
	5. Full Time Student Attending _____ Expected Date of Graduation _____			
IF DUE TO AN ACCIDENT, ANSWER ITEMS 6-10	6. Date of Accident _____		7. Place of Accident _____	8. Was Patient at Work When Accident Occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No
	9. Briefly Describe Accident _____			10. Was the accident Due to Someone's Negligence? <input type="checkbox"/> Yes <input type="checkbox"/> No

GIVE THE FOLLOWING INFORMATION ABOUT OTHER INSURANCE/MEDICARE

11. Any other Medical benefits for employee, spouse, or patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent If Dependent or Spouse, Full Name _____ Date of Birth _____ Coverage Paid Through <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Effective Date _____ Last Day of <input type="checkbox"/> Employer Sponsored Plan <input type="checkbox"/> Private Policy <input type="checkbox"/> Champus of Coverage _____ Effective Coverage _____ Give Name of Other Insurance Company _____ Phone Number of Other Insurance Company _____ Please Attach Other Insurance Explanation Of Benefits If Applicable
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GIVE THE FOLLOWING INFORMATION ABOUT YOURSELF

EMPLOYEE	12. Name (First) _____ (Middle Int.) _____ (Last) _____			13. Social Security Number _____	14. Date of Birth _____
					15. Sex <input type="checkbox"/> M <input type="checkbox"/> F
	16. Home Address (Number) _____ (Street) _____ (City) _____ (State) _____ (Zip Code) _____	17. Employer Name _____	18. Company Number _____	19. Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Cobra	20. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced

21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any Medical Information Necessary to Process this Claim.	22. AUTHORIZE FOR PAYMENT OF MEDICAL BENEFITS I hereby authorize payment of medical benefits to physician's or supplier's for services billed on this claim.
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SIGNED _____

DATE _____

SIGNED (Insured or Authorized Person) _____

23. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

Employee's Signature _____ Date _____

HEALTH BENEFITS CLAIM FORM

TO BE COMPLETED BY PHYSICIAN
(Not required if itemized billing attached)

TYPE OR PRINT

PHYSICIAN SUPPLIER INFORMATION					
1. PATIENT'S NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH		3. EMPLOYEE'S NAME (First name, middle initial, last name)	
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. EMPLOYEE'S SOCIAL SECURITY NUMBER	
		7. PATIENT'S RELATIONSHIP TO EMPLOYEE		8. EMPLOYER AND POLICY NUMBER	
		SELF	SPOUSE		
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number.		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S ADDRESS (Street, city, state, ZIP code)	
12. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	13. DATE FIRST CONSULTED YOU FOR THIS CONDITION		14. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
15. DATE PATIENT ABLE TO RETURN TO WORK	16. DATE OF TOTAL DISABILITY FROM _____ THROUGH _____		18. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		
17. NAME OF REFERRING PHYSICIAN			19. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		
			20. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES: _____		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE					
1.					
2.					
3.					
4.					
22. A. DATE OF SERVICE	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)		D. DIAGNOSIS CODE	E. CHARGES
				23. TOTAL CHARGE	24. TOTAL PAID
				25. BALANCE DUE	
26. SIGNATURE OF PHYSICIAN OR SUPPLIER		27. ACCEPT ASSIGNMENT (Government Claims only) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.	
SIGNED	DATE	30. PHYSICIAN'S SOCIAL SECURITY NO.		YOUR EMPLOYER I.D. NO.	
29. YOUR PATIENT'S ACCOUNT NO.					

*PLACE OF SERVICE CODES – THIS NUMBER IS REQUIRED TO BE FURNISHED UNDER AUTHORITY OF LAW

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|--------------------------------|-----------------------------|------------------------------------|-------------------------------------|
| 1 - (H) - INPATIENT HOSPITAL | 4 - (H) PATIENT'S HOME | 7 - (NH) - NURSING HOME | O - (OL) - OTHER LOCATIONS |
| 2 - (OH) - OUTPATIENT HOSPITAL | 5- DAY CARE FACILITY (PSY) | 8 - (SNF) SKILLED NURSING FACILITY | A - (IL) INDEPENDENT LABORATORY |
| 3 - (O) - DOCTOR'S OFFICE | 6- HOME CARE FACILITY (PSY) | 9 - AMBULANCE | B - OTHER MEDICAL/SURGICAL FACILITY |