Health Benefits Claim Form

To Be Completed By Member

For use with the Humana Family of Health Insurance and Health Plan Companies

INSTRUCTIONS

1. Complete ALL information requested below. We require the following information to make a decision:
   - •Receipt or other proof of your payment.
   - •An itemized statement from the provider showing the services provided with the date(s) of service for those services.
   - •The following information (if not included on the provider's itemized statement): revenue code(s), if applicable; CPT and/or HCPCS codes, if applicable; diagnosis code(s); and the place of treatment.
2. A completed form cannot include information for multiple family members, for multiple providers, or for multiple accidents/illnesses. Use a separate form for each family member, each provider, and each accident or illness.
3. Enclose ORIGINAL itemized bills. Please keep a copy for your records.
4. ASSIGNMENT: If you wish benefits to be paid directly to the physician or provider of service, sign the Direct Payment block below (item 13 below). (NOTE: Benefits for hospital confinement will be paid directly to the hospital.)
5. Mail completed form to the address on the back of your insurance card.

1. Employee/Member Name (Last) (First) (M.I.)	2. Member ID (11 characters):	3. Group Number:
4. Employee/Member Home Address	5. Group Name:	
	6. Employee/Member Birth Date:	7. Patient Birth Date:
8. Patient's Name (Last) (First) (M.I.)	9. Patient's Relationship to Employee:	

10. Services Date(s) From	To	Place of Service* (From List Below)	Was Service Furnished Via Audio/Video? Check One: ☐ Y ☐ N	CPT/HCPCS Code (Service Description)	Diagnosis Code(s)	Charge Per Unit/Day	Number of Units/ Days	Total Charge
			☐ Y ☐ N					
			☐ Y ☐ N					
			☐ Y ☐ N					
			☐ Y ☐ N					
			☐ Y ☐ N					
			☐ Y ☐ N					

***Place of Service Codes (Where You Were When You Received the Service(s) Listed Above)**

11 - Doctor's Office
12 - Patient's Home
19 - Hospital Outpatient Department (Off-campus)
20 - Urgent Care
21 - Inpatient Hospital
22 - Hospital Outpatient Department (On-campus)
23 - Emergency Room
24 - Ambulatory Surgical Center
31 - Skilled Nursing Facility
32 - Nursing Home
41 - Land Ambulance
42 - Air Ambulance
51 - Psychiatric Facility Inpatient
55 - Residential Substance Abuse Treatment Facility
72 - Rural Health Clinic
81 - Independent Laboratory
99 - Other Location

11. Provider (Facility, Professional, or Other Type of Supplier) Information

NAME of professional:
•
(Use "N/A" if claim is *not* for services furnished by a professional.)

If claim is *not* for services furnished by a professional, please provide the NAME of the provider:
•
(Use "N/A" if claim *is* for services furnished by a professional.)

NAME of group if professional is in a group practice:
•
(Use "N/A" if claim is *not* for services furnished by a professional in a group practice.)

PHONE NUMBER: ( ) -

TAX ID NUMBER:

ADDRESS (including ZIP code):

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim. I understand that, as permitted by law, to the extent of benefits paid under this claim, the Plan acquires all rights of recovery I may have against other parties.

Complete the Section Below Only If Payment Is To Be Sent Directly To Provider

I hereby authorize payment directly to the provider of services and I understand that I am financially responsible for the hospital, medical, or physician charges not covered by this authorization.

12. Patient's or Authorized Person's Signature	Date	13. Employee's Signature	Date

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

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