HEALTHAMERICA®
A Coventry Health Care Plan

BENEFIT CLAIM FORM

For PPO and POS Members

Employee Information (Please Print)

Name:	Last	First	MI	Social Security Number	Date of Birth	¨ Male ¨ Female	
Current Address:	Street	City	State	Zip	Daytime Phone No	Marital Status	¨ Single ¨ Widowed ¨ Married ¨ Divorced
Employer Name		Street	City	State	Zip		

Patient Information - Complete this section only if claim is for a qualified dependent.

Name: Last	First	MI		If age 19 or over ¨ Student ¨ Disabled If Student, Name of School, City and State:
Social Security No.	Date of Birth	Relationship	¨ Male ¨ Female	

Accident Information - Complete this section only if claim is result of Accident or work related Illness or Injury.

Date of Accident or first symptoms of Illness	Where did the Accident occur? (City/State)	Is Accident/Illness related to employment ¨ Yes ¨ No ¨ Auto Accident ¨ Other _____	Date patient first consulted physician for the condition:
Describe Accident Or Illness:			Has patient ever had same or similar symptoms? ¨ Yes ¨ No

Medicare Information - Complete this section only if patient is eligible for Medicare.

Please attach a copy of the "Explanation of Benefits" statement from your Medicare Insurance Carrier	Medicare Number	Effective Date Part A	Effective Date Part B

Other Health Insurance or HMO Coverage - This claim cannot be processed unless this section is complete.

Name of Policyholder	Policy Number	Insurance Company Name	Address	City	State	Zip

Authorization/Release of Information

ŸI authorize any insurance company, organization, employer, hospital, physician, pharmacist, or other health care provider to release any information requested with regard to this claim and the expenses reported.
ŸI certify that the information furnished in conjunction with the claim is true and correct.
Ÿ**PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.
OHIO: Any person who, with intent to defraud or knowing that he 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.

è _____
Patient or Authorized Person's Signature Date

I agree to assign benefits directly to the provider of services:_____
Employer or Authorized Person's Signature Date

Provider Statement of Services Rendered (Physician completes this Section:)

Name & Address of Facility where services were rendered (if other than home or office)					Date Admitted	Date Discharged
Diagnosis Code and Description: 1. 2.						
Date of Service From To	Place of Service	CPT-4 Procedure Code	Description of Services	Charges	Days or Units	
				Total Charge	Amount Paid	Balance Due

_____ _____
Signature of Provider Date

SEE REVERSE SIDE FOR INFORMATION ON HOW TO FILE A CLAIM

10/1/04

Provider Name | Tax I.D.#

Provider Address | Telephone #

HOW TO COMPLETE THIS BENEFIT CLAIM FORM

1. The employee or authorized person must complete the following sections of the benefit claim form:

   - § Employee Information
   - § Patient Information
   - § Accident Information
   - § Medicare Information
   - § Other Health Insurance
   - § Authorization/Release of Information

   This claim cannot be processed unless all sections that apply are completed. Claims for services provided by a nonparticipating provider **must** be submitted on this benefit claim form.

2. Submitting the claim form: If the provider is a nonparticipating provider, you are responsible for filing the claim.

Mail the completed Benefit Claim Form to:

Central and Eastern Pennsylvania
HealthAmerica Claims
P.O. Box 7089
London, KY 40742

Western Pennsylvania & Ohio
HealthAmerica Claims
P.O. Box 7088
London, KY 40742

3. Additional Benefit Claim Forms may be obtained from your employer, by contacting HealthAmerica or by downloading a claim form at www.healthamerica.cvty.com.

   If you have any questions, call Customer Service at **1-800-735-4404** in western Pennsylvania and Ohio, or **1- 800-788-8445** in central and eastern Pennsylvania.