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.
2. Use separate form for each family member and for each accident or illness.
3. Enclose ORIGINAL itemized bills. Please keep a copy for your records. Cancelled checks ARE NOT acceptable.
4. ASSIGNMENT: If you wish benefits to be paid directly to the physician or provider of service, sign the Direct Payment block 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. Service Dates From	To	Place of Service*	CPT Code/Service Description	Diagnosis Code	Unit Charges	Days or Units	Total Charges

*****Place of Service Codes

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

11. Physician, Supplier and/or Group Name Address, Zip Code, Telephone No. and Tax ID No.

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 considered responsible for these expenses.

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

Any person who knowingly and with intent to defraud any insurance company and 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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