

Statement of Claims

MEDICA®

If you have questions in completing this form, please contact our Customer Service Department at 952-945-8000 or toll free outside the Twin Cities metro area at 1-800-952-3455. Hearing-impaired members can reach us by calling the National Relay Center at 1-800-855-2280 and asking for the number above.

Medica
P.O. Box 30990
Salt Lake City, UT 84130

Throughout this form, all self-insured enrollees will be referred to as "members" rather than their formal title of "self-insured enrollees."

Note: For Pharmacy claims, please use the Pharmaceutical Prescription Claim Form. For foreign claims, please contact Customer Service at the phone number on the back of your ID card for special instructions.

TO BE COMPLETED BY MEMBER

Member Information	
1. Member's name	2. Employer's name
3. Member ID Number (9 digits) 	4. Group/Policy number (5 or 6 digits, not the Payer ID)
5. Residence street address	City State Zip
Patient Information	
6. Patient's name	7. Patient's date of birth
8. Describe illness or injury	9. Give date it began
10. Was this claim due to one of the following? <input type="checkbox"/> Auto accident <input type="checkbox"/> Dental injury <input type="checkbox"/> Emergency <input type="checkbox"/> Mental health or substance abuse	
11. If injury, was it job related? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain:	
12. Do you or any member of your immediate family have any other group insurance which may cover all or part of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give insurance company name, address and group policy number:	

A person who submits an application or files a claim with intent to defraud or helps commit fraud against an insurer is guilty of a crime.

Authorization: On behalf of myself and any patient named on this claim form ("Us"), I authorize any health care professional or entity, employer, union, insurance company, health maintenance organization, other health plan company or prepayment organization to give Medica Health Plans, Medica Insurance Company, Medica Health Plans of Wisconsin, or Medica Self-Insured and my employer, or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for evaluation of this claim, and for any analytical or research purposes. This authorization will automatically expire one year following the date of signature without my express revocation.

Member's signature	Date
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Please check to see that this entire claim form has been properly completed and signed prior to submitting to Medica. Payment will be made to you, unless you sign #13 on the Health Insurance Claim Form, or specifically direct otherwise.

Mail these forms and/or itemized bills to:
Medica
P.O. Box 30990
Salt Lake City, UT 84130

Instructions for Health Insurance Claim Form

The following fields need to be completed on the attached Health Insurance Claim Form in order for your claim to be processed. This is just a guide.



1. Patient's Name
2. Patient's Date of Birth
3. Insured's Name
4. Patient's Address
5. Patient's Sex
7. Patient's Relationship to Insured
10. Was Condition Related To
12. Patient's or Authorized Person's Signature
19. Name of Referring Physician or Other Source
23. Diagnosis or Nature of Illness or Injury
- 24.A Date of Service
- 24.B Place of Service Code

- If you are unsure what the Place of Service Code for your situation is, please see some of the most common codes below. If none of the codes listed apply to you, you may need to ask your provider for the information needed to complete this field.

11. **Office.** Location where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury.
20. **Urgent Care Facility.** Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21. **Inpatient Hospital.** A facility, other than psychiatric, which primarily provides care, and rehabilitation services by, or under, the supervision of physicians to patients admitted for greater than 24 hours.
22. **Outpatient Hospital.** A facility, other than psychiatric, which primarily provides care, and rehabilitation services by, or under, the supervision of physicians to patients admitted for less than 24 hours.
23. **Emergency Room – Hospital.** A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24.C Fully Describe Procedures, Medical Services, or Supplies for each date given
(You will need to ask your provider for the information to complete this field)

24.D Diagnosis Code
(You will need to ask your provider for the information to complete this field)

24.E Charges

27. Total Charge

31. Physician's or Supplier's Name, Address, Zip Code, Telephone Number and Federal Tax ID Number

If this is a Mental Health or Substance Abuse claim, please check the Mental Health/Substance Abuse box at the top of the Health Insurance Claim Form.

You also need to include copies of any bills, receipts or itemized statements from all providers. **Please make sure your 5 or 6 digit Group or Policy number and your 9 digit ID number are listed on all pages of correspondence that are submitted.** Please make copies of all correspondence (keep one copy for your own records) and send a legible copy of all documents, including the completed claim forms to:

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Salt Lake City, UT 84130

Please Note:
This is just a guide. Please fill in your information on the attached Health Insurance Claim Form

