Claim Form

USE A SEPARATE FORM FOR EACH PATIENT

GROUP NO. (FROM ID CARD)

MEMBER ID NO. (FROM ID CARD)

General Instructions:
Make sure you and your physician or other health care professional fill out this form completely in order for you to receive timely reimbursement for paid medical services.

- Type or print requested information.
- Ask your provider(s) to help you complete all information in sections C and D.
- Attach itemized receipts or claim forms for each service. (Do not staple items.)
- A separate reimbursement request form should be completed for each patient.
- Please keep a copy of each itemized bill or receipt for your records. Do not submit a form if your physician or other health care professional is also filing a claim to MyTruAdvantage for the same service.

A. PATIENT INFORMATION		
PATIENT NAME (Print):	Sex: ☐ M ☐ F	BIRTH DATE: ____ / ____ / ____
RELATIONSHIP TO EMPLOYEE: ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER		
B. EMPLOYEE INFORMATION		
EMPLOYEE NAME (Print):	CHECK IF NEW ADDRESS: ☐	
EMPLOYEE ADDRESS:		
CITY:	STATE:	ZIP:
C. PROVIDER INFORMATION		
PROVIDER NAME:	TAX ID #:	NPI #:
PROVIDER ADDRESS:		
CITY:	STATE:	ZIP:

D. SERVICE INFORMATION

Date (mm/dd/yy)	Place of Service	Codes for Procedures, Services or Supplies	Diagnosis Code	Charges	Number of Units
				TOTAL Charges	**Amount Paid by You**

Over (please complete both pages) →

MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal.
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E. OTHER INSURANCE INFORMATION

IS PATIENT COVERED BY ANOTHER MEDICAL PLAN? ☐ YES ☐ NO

IF YES, INDICATE MEDICAL PLAN NAME: POLICY NO.:

MEMEMBER ID NO.: EFFECTIVE DATE OF COVERAGE:

MEDICAL PLAN ADDRESS:

CITY: STATE: ZIP:

EMPLOYER NAME: PHONE:

EMPLOYEE BIRTH DATE: _____ / _____ / _____ SPOUSE BIRTH DATE: _____ / _____ / _____

IF YOU ARE ELIGIBLE FOR MEDICARE:

- Submit bills for all charges except prescription drugs to Medicare first. Mare sure you keep a copy of the itemized bill, since you will also need to submit it to MyTruAdvantage.
- You will receive the Explanation of Benefits Statement from Medicare, indicating payment or denial of your claim submission. Submit the Medicare statement and a copy of the itemized bill also, since you need to send it to MyTruAdvantage once you receive Medicare's Explanation of Benefits.
- Some physicians and other medical provides will file your Medicare claims directly for you. You need to tell them to send you a copy of the itemized bill also, since you need to send it to MyTruAdvantage once you receive Medicare's Explanation of Benefits.

F. PATIENT AUTHORIZATION

To all physicians and other medical professionals, hospitals and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit administrators:

- You are authorized to provide any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on SIHO's (d.b.a. MyTruAdvantage) behalf, with information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.
- I hereby authorize MyTruAdvantage to provide the information relating to medical services and treatment rendered to me and/or my dependents.
- I understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.
- I have furnished the information on this form so that MyTruAdvantage may consider this claim. By signing below, I certify the information is correct and the expenses were incurred by the patient named above.
- Should there be an overpayment in excess of the amount payable under the Medical Plan, I agree to reimburse MyTruAdvantage to the extent of the overpayment.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: DATE:

RELATIONSHIP OF AUTHORIZED PERSON:

G. PAYMENT AUTHORIZATION

PAY TO PROVIDER	PAY TO ME
☐ I authorize benefits to be paid directly to the physician or other provider of service.	☐ I authorize benefits to be paid to me. I understand it is my responsibility to pay the physician, hospital or other provider of service.
EMPLOYEE/RETIREE/SURVIVOR SIGNATURE: DATE:	EMPLOYEE/RETIREE/SURVIVOR SIGNATURE: DATE:

Before you submit your claim…	**SUBMIT TO:**
1. Be sure all fields are completed. 2. Write your Member ID on all paperwork you submit. 3. Make photocopies of all receipts and completed forms. Receipts will not be returned.	PO Box 428 Columbus, IN 47202 CALL TOLL-FREE: (844) 425-4280 (TTY:711)