MyTru Advantage

Claim Form

USE A SEPARATE FORM FOR EACH PATIENT

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.

MEMBER ID # (ON ID CARD)

- 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 member.
- 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. MEMBER INFORMATION

CHECK IF NEW ADDRESS: ☐

MEMBER NAME (Print):		
MEMBER ADDRESS:		
CITY:	STATE:	ZIP:

B. PROVIDER INFORMATION

PROVIDER NAME:	TAX ID #:	NPI #:
PROVIDER ADDRESS:		
CITY:	STATE:	ZIP:

C. SERVICE INFORMATION

DATE (MM/DD/YY)	PLACE OF SERVICE	CODES FOR PROCEDURES, SERVICES OR SUPPLIES	DIAGNOSIS CODE	# OF UNITS	CHARGES
					$
					$
					$
					$
			$		$
			TOTAL Charges		**Amount Paid by You**

D. OTHER INSURANCE INFORMATION

DO YOU WORK AND HAVE HEALTH INSURANCE? ☐ YES ☐ NO		
DOES YOUR SPOUSE WORK AND PROVIDE YOU WITH HEALTH INSURANCE? ☐ YES ☐ NO		
IF YES, NAME OF OTHER HEALTH COVERAGE:		
MEMBER ID NO.:	EFFECTIVE DATE: _____ / _____ / _____	
MEDICAL PLAN ADDRESS:		
CITY:	STATE:	ZIP:
POLICY NO.:	SPOUSE BIRTH DATE: _____ / _____ / _____	

Over (please complete both pages) →

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E. MEMBER 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 member. 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 member 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.

MEMBER OR AUTHORIZED PERSON'S SIGNATURE:	DATE:
	_____ / _____ / _____
RELATIONSHIP OF AUTHORIZED PERSON:	

F. 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.	
MEMBER/SURVIVOR SIGNATURE:	DATE:	MEMBER/SURVIVOR SIGNATURE:	DATE:
	____ / ____ /____		____ / ____ /____