


HEALTH CARE BENEFITS CLAIM FORM


THIS SIDE TO BE COMPLETED BY EMPLOYEE
(Reverse side to be completed by Provider)

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. Receipts and cancelled checks ARE NOT acceptable.
- 4 ASSIGNMENT: If you wish benefits to be paid directly to the physician or provider of service, sign in the Direct Payment block below. NOTE: Benefits for a hospital confinement will be paid directly to the hospital.


Check here if covered through COBRA continuation provision.

1 Employee's Name (Last) (First) (M.I.)		2 Social Security Number (I.D. Number)		3 Group Number (First 6 digits)	
4 Employee's Home Address		5 Group Name (if Humana Inc. employee, facility where employed)			
		6 Employee's Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled		7 Date of Retirement or Disability	8 Employee's Birth Date
9 Patient's Name (Last) (First) (M.I.)		10 Patient's Relationship to Employee <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____			
11 Patient's Birth Date	12 Patient's Employment Status <input type="checkbox"/> Active (If so, where employed: _____) <input type="checkbox"/> Retired _____ <input type="checkbox"/> Disabled _____	CHILD  <input type="checkbox"/> UNDER 19 <input type="checkbox"/> HANDICAPPED <input type="checkbox"/> FULL - TIME STUDENT <input type="checkbox"/> PART - TIME STUDENT <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED		Expected Date of Graduation	
13 Patient's Sex <input type="checkbox"/> M <input type="checkbox"/> F				Name of School	
14 Is Patient covered by other group health plan? <input type="checkbox"/> YES <input type="checkbox"/> NO	15 Name and Address of Other Carrier	17 Is your spouse employed? <input type="checkbox"/> YES <input type="checkbox"/> NO	18 Name, Address and Telephone of Spouse's Employer		
16 Plan/Policy Number		19 Spouse's Birth Date	Social Security Number		

IF CLAIM IS ACCIDENT-RELATED, COMPLETE THIS SECTION		20 Accident Date	29 Did the accident involve a motor vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO	30 Name and Address of Your Vehicle Insurance Carrier	
		21 Accident Time			
22 Did the accident occur while on the job? <input type="checkbox"/> YES <input type="checkbox"/> NO		23 Did the accident occur on another person's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO	24 Name and Address of Person on Whose Premises the Accident Occurred	31 Did you file a claim with your vehicle insurance carrier? <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, attach a copy of the claim submitted)	32 Name and Address of Other Vehicle Owner Involved
25 Did accident occur while using a product or item? <input type="checkbox"/> YES <input type="checkbox"/> NO	26 Name of Product or Item	27 Place of Purchase	33 Was a police report made? <input type="checkbox"/> YES <input type="checkbox"/> NO	34 Name and Address of Other Vehicle Owner's Insurance Carrier	
28 Do you believe another party was responsible for or caused the accident? <input type="checkbox"/> YES <input type="checkbox"/> 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.	
35 Patient or Authorized Person's Signature	Date

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.	
36 Employee's Signature	Date

 **Any person who knowingly causes to be prepared or who presents a false or fraudulent claim to an insurer for the payment of a loss is guilty of the crime of insurance fraud and may be subject to fines and confinement in a state prison, among other things.**

THIS SIDE TO BE COMPLETED BY ATTENDING PHYSICIAN OR PROVIDER

INSTRUCTIONS

- ① List procedures, medical service and/or supplies for: Surgery - Doctor's Visits - Hospital Confinement - Mental Illness Expenses
- ② Include CPT-4 procedure, ICD-9 diagnosis, place of service, type of service and specialty codes for each service provided or as required.
- ③ IF ASSIGNED BENEFITS (Benefits are automatically assigned to the physician for patients with HMO coverage).
 - Send completed claim form and itemized bills to: Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601
 - Itemized bills should include: Employee Name - Date and Type of Service - Charge for Service - Patient Name - Diagnosis
 - Drug bills must be originals ONLY and include: Patient and Physician Names - Charge Amount - Prescription Number and Date - Drug Name
 - Be certain to include the Physician's or Provider's Federal Tax Identification Number. The claim WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

1 Date of	Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	2 Date first consulted you for this condition	3 If Patient has had same or similar illness or injury, give dates	4 If Emergency, Check here <input type="checkbox"/>
5 Date Patient able to return to work	6 Dates of Total Disability From _____ Through _____		7 Dates of Partial Disability From _____ Through _____	
8 Name and Phone Number of Referring Physician or other Source (e.g., Public Health Agency)			9 For services related to Hospitalization, give Hospitalization dates Admitted _____ Discharged _____	
10 Name and Address of Facility where services rendered (if other than home or office)			11 Was Lab Work performed outside your office? <input type="checkbox"/> YES <input type="checkbox"/> NO	12 Authorization No. Charges: _____
13 Principal Diagnosis - 1	14 ICD-9-CM Code	15 Additional Diagnosis - 2		16 ICD-9-CM Code
17 Additional Diagnosis - 3	18 ICD-9-CM Code	19 Additional Diagnosis - 4		20 ICD-9-CM Code

RELATE DIAGNOSIS TO PROCEDURE IN DIAGNOSIS CODE COLUMN BY REFERENCE NUMBERS 1, 2, 3, 4

21 SERVICE DATES		* POS	CPT-4 CODE	MODIFIER	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	DIAGNOSIS CODE	UNIT CHARGES	DAYS OR UNITS	** TOS	TOTAL CHARGES
FROM	TO									

22 Signature of Physician or Supplier (including Degree(s) or Credential(s)) I certify that the services were provided by me and were medically necessary.			23 Total Charge	24 Amount Paid	25 Balance Due
26 Physician's, Supplier's, and/or Group Name, Address, Zip Code, Telephone No. and I.D. No.					
27 Your Social Security No.	28 Your Patient's Account No.	29 Your Employer I.D. No.		*** SC	

*PLACE OF SERVICE CODES

1 - Inpatient Hospital (H)
2 - Outpatient Hospital (OH)
3 - Doctor's Office (O)
4 - Patient's Home (H)
5 - Day Care Facility (PSY)
6 - Night Care Facility (PSY)
7 - Nursing Home (NH)
8 - Skilled Nursing Facility (SNF)
9 - Ambulance
0 - Other Locations (OL)
A - Independent Laboratory (IL)
B - Other Medical/Surgical Facility
C - Residential Treatment Center (RTC)
D - Specialized Treatment Center (STF)

**TYPE OF SERVICE CODES

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
F - Ambulatory Surgical Center
H - Hospice
L - Renal Supplies in the Home
M - Alternate Payment for Maintenance Dialysis
N - Kidney Donor
V - Pneumococcal Vaccine
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

***SPECIALTY CODES

AI - Allergy and Immunology	ON - Oncology
AN - Anesthesiology	OPH - Ophthalmology
CD - Cardiovascular Diseases	OTO - Otorhinolaryngology
DC - Chiropractic Services	PTH - Pathology
D - Dermatology	PD - Pediatrics
EM - Emergency Medicine	PM - Physical Medicine and Rehabilitation
END - Endocrinology	DPM - Podiatry
FP - Family Practice	P - Psychiatry
GE - Gastroenterology	PUD - Pulmonary Diseases
GP - General Practice	R - Radiology
GER - Geriatrics	TR - Radiology, Therapeutic
HEM - Hematology	CDS - Surgery, Cardiovascular
ID - Infectious Diseases	GS - Surgery, General
IM - Internal Medicine	NS - Surgery, Neurological
MFS - Maxillofacial Surgery	ORS - Surgery, Orthopedic
NEP - Nephrology	PS - Surgery, Plastic
N - Neurology	TS - Surgery, Thoracic
NPM - Neonatal-Perinatal Medicine	U - Surgery, Urological
NM - Nuclear Medicine	OS - Other
OBG - Obstetrics/Gynecology	