Hometown Health Providers

MEDICAL CLAIM FORM

GROUP NAME _____ GROUP # _____

HOW TO PRESENT A CLAIM

1. Complete the "Employee Information" below. A separate form will be required for each family member. To avoid delay be sure to answer all questions.
2. Have the **doctor** complete the **reverse** side of this form or attach itemized billing from your doctor. If you have more than one doctor, the information should be provided by the physician who rendered the most service, or in the case of surgery, by the primary surgeon.
3. Bills submitted for each person must show (a) name of the patient, (b) type of service rendered, (c) date of service rendered and (d) the amount of the charge. Bills and receipts for drugs and medicine must show the (a) name of the patient (b) prescribing physician (c) prescription number or nature of medication, (d) date of purchase and (e) charge for each prescription.

WHERE TO SEND A CLAIM

Hometown Health Providers Insurance Co.
10315 Professional Circle
Reno, NV 89521

PHONE CLAIM INQUIRIES
775-982-3232
1-800-336-0123

EMPLOYEE INFORMATION

EMPLOYEE'S NAME			SEX: M ☐ F ☐	MARITAL STATUS	MEMBER ID NO.
Last	First	Middle		☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Legally Separated	

EMPLOYEE'S ADDRESS				DATE OF BIRTH		
Number and Street	City	State	Zip Code	Month	Day	Year

SECTION 1. a. Is your spouse employed? ❑ Yes ❑ No
b. If claim is for any child, is that child employed? ❑ Yes ❑ No

If the answer to either is "Yes," please show in "Remarks" the names of the persons who are employed, and the name and address of their respective employers.

SECTION 2.

a. Other Group Health insurance/coverage of any kind? ❑ Yes ❑ No
b. Group prepayment arrangement providing for medical care and treatment? ❑ Yes ❑ No
c. Coverage of medical care expenses provided by a school, or by Medicare or other federal, state, provincial or government agency? ❑ Yes ❑ No
d. No fault automobile insurance as a result of injuries sustained in an automobile accident? ❑ Yes ❑ No

If any of the above are answered "yes," please indicate in "Remarks" the policy number, insurance company and the name and address of the school, employer, union or governmental agency.

SECTION 3.

Was illness or injury due, in any way:

a. To the patient's occupation? ❑ Yes ❑ No
b. To an automobile accident? ❑ Yes ❑ No
c. Any other type of accident? ❑ Yes ❑ No

If any of above are answered "Yes," give details under "Remarks". If accident involved, include date of accident and extent of injuries

REMARKS: Please indicate which question you are answering by giving Section and Question number, such as 2a. (If additional space is needed, attach separate page).

DEPENDENT INFORMATION Complete only if patient is a dependent.

DEPENDENT'S NAME			SEX: M ☐ F ☐	MARITAL STATUS	DATE OF BIRTH		
Last	First	Middle		☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Legally Separated	Month	Day	Year

RELATIONSHIP		DATE OF BIRTH			MEMBER ID NO.
☐ Spouse ☐ Child ☐ Other	**IF CLAIM IS FOR DEPENDENT CHILD PLEASE INDICATE SPOUSE'S DATE OF BIRTH AND MEMBER ID NO.**	Month	Day	Year	

IF CLAIM IS FOR DEPENDENT CHILD 19 OR OLDER	
Is child enrolled as full time student? ❑ Yes ❑ No	If Yes, give name of school

The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization to release to each other, any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A photostat of this authorization shall be as valid as the original.

Employee's Signature _____ Date _____

Patient's Signature (Parent, if patient is a minor) _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of benefits directly to the Physician signing the reverse side of this form.

SIGNED (COVERED ENROLLEE) _____ DATE _____

X

6045