MEMBER REIMBURSEMENT CLAIM FORM

SEND COMPLETED CLAIM FORM TO:
HMA, LLC
P.O. BOX 22009 TEMPE, AZ 85285-2009

EMPLOYEE INFORMATION: Employee Complete This Section

EMPLOYEE'S NAME:	DATE OF BIRTH:	SEX: M F
EMPLOYEE'S MAILING ADDRESS:		
EMPLOYEE'S PHONE NUMBER:	E-MAIL ADDRESS:	MARITAL STATUS: SINGLE MARRIED
EMPLOYEE ID:	PLAN #/GROUP #:	EMPLOYER NAME:

PATIENT INFORMATION: Complete Only If Patient Is Other Than Employee

PATIENT'S NAME:	RELATIONSHIP TO EMPLOYEE: SPOUSE CHILD	DATE OF BIRTH:	SEX: M F

OTHER COVERAGE (MUST BE COMPLETED)

DOES PATIENT HAVE OTHER HEALTH INSURANCE? YES NO IF YES, PLEASE COMPLETE INFORMATION IN THIS SECTION.

NAME AND SOC. SEC. NO. OF POLICYHOLDER:_____SSN:_____

BIRTHDATE OF POLICYHOLDER: MONTH_____ DAY_____ YEAR_____

NAME AND ADDRESS OF OTHER INSURANCE COMPANY: _____

POLICY OR CERTIFICATE #:_____ EFFECTIVE DATE: MONTH_____ DAY_____ YEAR_____

TYPE OF COVERAGE ON THIS POLICY: MEDICAL DENTAL VISION
(Circle all applicable coverage's)

ABOUT THE CLAIM (MUST BE COMPLETED)

NAME OF PROVIDER:	PROVIDER'S PHONE NUMBER:	DATE OF SERVICE(S):

DESCRIBE THE ILLNESS, ACCIDENT OR CONDITION:_____

HAVE YOU EVER BEEN TREATED FOR THIS CONDITION? YES NO IF YES, WHAT DATE?_____

WERE SERVICES USED AS A RESULT OF AN ACCIDENT? YES NO IF YES, WAS THE ACCIDENT:

AN AUTO ACCIDENT AT WORK AT HOME OTHER_____

WHEN DID THE ACCIDENT HAPPEN? MONTH_____ DAY_____ YEAR_____

YOU MUST SUBMIT ONE OF THE FOLLOWING ITEMS WITH THIS FORM FOR YOUR CLAIM TO BE CONSIDERED FOR REIMBURSEMENT:

SUPERBILL ITEMIZED RECEIPT ITEMIZED STATEMENT INVOICE

SIGNATURES IN THIS SECTION MUST BE PROVIDED OR WE WILL NOT PROCESS THE CLAIM.

I have furnished the information on this form so that HMA, INC. may consider this claim. By signing below, I certify that the information is correct and that the expenses were incurred by the patient named above. If any money is paid on this claim in error, or not authorized by the contract, I agree to return it to my Employer Health Plan.

PARTICIPANT'S SIGNATURE DATE:_____ MONTH_____ DAY_____ YEAR_____

AUTHORIZATION TO RELEASE INFORMATION

I authorize any insurance company, employer, organization or provider of services to release any information related to this claim to HMA, INC before or after payment.

PATIENT'S SIGNATURE DATE:_____ MONTH_____ DAY_____ YEAR_____
(OR PARENT/GUARDIAN)