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.

3 Group Number (First 6 digits)

1 Employee's Name (Last) (First) (M.I.)

2 Social Security Number (I.D. Number)

4 Employee's Home Address

5 Group Name (if Humana Inc. employee, facility where employed)

6 Employee's Employment Status ☐ Active ☐ Retired ☐ 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 ☐ SELF ☐ SPOUSE ☐ OTHER ______

CHILD ☐ UNDER 19 ☐ HANDICAPPED ☐ FULL - TIME STUDENT ☐ PART - TIME STUDENT ☐ SINGLE ☐ MARRIED

Expected Date of Graduation

Name of School

11 Patient's Birth Date

12 Patient's Employment Status ☐ Active (If so, where employed: ______ ☐ Retired ______ ☐ Disabled ______)

13 Patient's Sex ☐ M ☐ F

14 Is Patient covered by other group health plan? ☐ YES ☐ NO

15 Name and Address of Other Carrier

16 Plan/Policy Number

17 Is your spouse employed? ☐ YES ☐ NO

18 Name, Address and Telephone of Spouse's Employer

19 Spouse's Birth Date

Social Security Number

IF CLAIM IS ACCIDENT-RELATED, COMPLETE THIS SECTION

20 Accident Date

21 Accident Time

22 Did the accident occur while on the job? ☐ YES ☐ NO

23 Did the accident occur on another person's premises? ☐ YES ☐ NO

24 Name and Address of Person on Whose Premises the Accident Occurred

25 Did accident occur while using a product or item? ☐ YES ☐ NO

26 Name of Product or Item

27 Place of Purchase

28 Do you believe another party was responsible for or caused the accident? ☐ YES ☐ NO

29 Did the accident involve a motor vehicle? ☐ YES ☐ NO

30 Name and Address of Your Vehicle Insurance Carrier

31 Did you file a claim with your vehicle insurance carrier? ☐ YES ☐ NO (If YES, attach a copy of the claim submitted)

32 Name and Address of Other Vehicle Owner Involved

33 Was a police report made? ☐ YES ☐ NO

34 Name and Address of Other Vehicle Owner's Insurance Carrier

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 isurer 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 appropriate claims office address as shown on the back of attached envelope.
   - 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 ☐

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? ☐ YES ☐ NO Charges:

12 Authorization No.

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

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.

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