QualChoice® HEALTH INSURANCE

Medical Claim Form

Fill out this form only if your healthcare provider is not submitting the claim for you. See instructions for completing the form on the back.

Section I: Employee Information

Employer's Name			
Employee's Name (Last, First, Middle Initial)			Date of Birth (MM/DD/YYYY)
Employee's Mailing Address Is this a new address? ☐ YES ☐ NO	City	State	Zip
Employee's QualChoice ID Number (on front of your ID card)	Daytime Telephone No.		

Section II: Patient Information *Complete this section ONLY if patient is not the employee.*

Patient's Name (Last, First, Middle Initial)	Relationship to Employee ☐ Spouse ☐ Dependent ☐ Other	Date of Birth	Gender ☐ Male ☐ Female
Patient's Address (if different than employee address)	City	State	Zip
At the time medical service was provided, was the patient employed: ☐ Full Time ☐ Part Time If student: ☐ Full Time ☐ Part Time ☐ N/A			

Section III: Accident/Occupational Claim Information *Complete this section ONLY if claim is a result of an accident or occupational (work related) injury.*

Is claim related to employment? ☐ YES ☐ NO If yes, please file with your worker's compensation carrier first.	Is claim related to auto accident? ☐ YES ☐ NO	Date of Accident or Beginning of Illness
Description of how accident or work related illness/injury occurred. Use separate sheet if necessary.		
Is a claim or lawsuit being filed against a 3rd party, including an insurance company, in order to recover the expenses incurred as a result of this accident or illness? ☐ YES ☐ NO If yes, name of third party:_____		
Did accident/illness occur outside the United States? ☐ YES ☐ NO If yes, all statements must be translated into English.		

Section IV: Dependent/Other Coverage Information *Complete this section ONLY if claim is for a dependent/spouse and/or other coverage is in effect.*

Name of Dependent/Spouse (Last, First, MI)	Date of Birth	Is dependent/spouse employed? ☐ YES ☐ NO	If NO, has dependent/spouse been employed during the last 12 months? ☐ YES ☐ NO	
Name of Health Insurance Company		City	State	Zip
Policy Number	Effective Date of Coverage	Is the dependent spouse covered under any other health insurance plan or Medicare? ☐ YES ☐ NO If yes, name of third party? _____		

Ssection V: Payment Instructions

By signing below, I affirm in writing that I have not assigned QualChoice benefits to my healthcare provider. I also certify the above is complete and accurate and authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s).

Employee Signature (Required) X	Date (MM/DD/YYYY)

Important Information

1. We pay covered claims directly to any contracted in-network healthcare provider. If you have already paid for these services, please seek reimbursement directly from the healthcare provider.
2. The information provided on this form may be disclosed to other persons or entities, including plan sponsors, for the purpose of processing this claim and performing health plan administration.
3. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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INSTRUCTIONS

1. Determine the type of claim you will be filing. (either A. or B.)

A. Filing a claim for services provided by a physician or other non-facility provider:
You must include an original CMS-1500 Health Claim Form issued to you by the physician or the non-facility provider – or you may submit an original itemized bill issued to you by the provider of service.

Itemized bills must contain the following information:

- Date of service and diagnosis
- Employee name and QualChoice ID number
- Patient name and date of birth
- Diagnosis and procedure code(s)
- Provider name and address
- Provider Tax ID Number and National Provider Index (NPI) number (or other medical provider who provided the service)
- Amount charged for each service

B. Filing a claim for services provided by a hospital or other facility:
You must include an original UB-04 form issued to you by the hospital or other facility.

2. An itemized bill must be submitted for your claim to be processed.

The following items are not acceptable documentation: cash register receipts, cancelled checks, money order receipts, handwritten claims, or personal lists. The member must provide original documents.

3. The Medical Claim Form cannot be processed without the insured's ID number.

To process your claim we need the insured's QualChoice ID card. This number is located on the front of the insured's ID card.

4. A separate Medical Claim Form must be submitted for each eligible member.

NOTE: Only one claim form per member is needed regardless of the number of receipts.

5. Your claim may be rejected for the following reasons:

- If any information is missing, altered, or unclear.
- If claim form from the healthcare provider is handwritten.
- If claim form is not accompanied by a UB-04, CMS-1500 or original itemized bill.
- If UB-04 and CMS-1500 claim forms are not submitted on red and white paper (not black & white and no copies).
- If claim is submitted past the required time frame.
- If member has assigned QualChoice benefits to the healthcare provider.

6. You are encouraged to submit claim(s) within 60 days of the date of service.

Claims must be received by QualChoice within one year of the date of service to be eligible for payment.

7. Be sure to retain a copy of your bills for your record.

What to suBmit:

1. *Medical Claim Form* (completed and signed by insured)
2. If physician or non-facility provider: Include original CMS-1500 Health Claim Form (see A. above) or original itemized bill.
3. If hospital or other facility: Include original UB-04 form (see B. above).

8. Mailing Instructions

Please fax or mail completed form to:

QualChoice
ATTN: Claims Processing
P.O. Box 25610
Little Rock, AR 72221
Fax: 833.681.2495

NOTE:

Your *Benefit Summary* and *Certificate of Coverage* or *Coverage Policy* plan documents describe covered services under your health plan. Submission of this form does not guarantee reimbursement. For questions, call Customer Service at 501.228.7111 or 800.235.7111, Monday through Friday, 8:00 a.m. to 5:00 p.m., Central Time.

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