

Health Benefits Claim Form

To Be Completed By Member

For use with the Humana Family of Health Insurance and Health Plan Companies

| | |
|---------------------|--|
| INSTRUCTIONS | <p>1. Complete ALL information requested below.</p> <p>2. Use separate form for each family member and for each accident or illness.</p> <p>3. Enclose ORIGINAL itemized bills. Please keep a copy for your records. Cancelled checks ARE NOT acceptable.</p> <p>4. ASSIGNMENT: If you wish benefits to be paid directly to the physician or provider of service, sign the Direct Payment block below. NOTE: Benefits for hospital confinement will be paid directly to the hospital.</p> <p>5. Mail completed form to the address on the back of your insurance card.</p> |
|---------------------|--|

| | | |
|---|--|------------------------|
| 1. Employee/Member Name (Last) (First) (M.I.) | 2. Member ID (11 characters): | 3. Group Number |
| 4. Employee/Member Home Address | 5. Group Name | |
| | 6. Employee/Member Birth Date: | 7. Patient Birth Date: |
| 8. Patient's Name (Last) (First) (M.I.) | 9. Patient's Relationship to Employee: | |

| 10. Service Dates | | Place of Service* | CPT Code/Service Description | Diagnosis Code | Unit Charges | Days or Units | Total Charges |
|-------------------|----|-------------------|------------------------------|----------------|--------------|---------------|---------------|
| From | To | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

- | *Place of Service Codes |
|---|
| <ul style="list-style-type: none"> 11- Doctor's Office 12- Patient's Home 20- Urgent Care 21- Inpatient Hospital 22- Outpatient Hospital 23- Emergency Room 31- Skilled Nursing Facility 32- Nursing Home 33- Other Medical/Surgical Facility 41- Ambulance 52- Psychiatric Facility 55- Residential Treatment Center 72- Rural Health Clinic 81- Independent Laboratory 99- Other Locations |

| |
|--|
| 11. Physician, Supplier and/or Group Name Address, Zip Code, Telephone No. and Tax ID No. |
| |

| RELEASE OF INFORMATION | If Payment Is To Be Sent Directly To Provider |
|---|---|
| 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. | 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. |
| 12. Patient or Authorized Person's Signature | 13. Employee's Signature |
| Date | Date |

Any person who knowingly and with intent to defraud any insurance company and files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

GNA02NHHH