

INSTRUCTIONS FOR SUBMITTING CLAIMS

1. Use a separate form for each family member, each different provider of service, and each itemized bill.
2. Attach a fully itemized ORIGINAL bill. Keep a copy for your records.
FULLY ITEMIZED BILLS MUST CONTAIN THE FOLLOWING INFORMATION:
 date(s) of service, diagnosis(es), type(s) of service, procedure code(s), charge for each service, provider name and type of license, address, phone number, provider tax ID number and provider NPI number (both are necessary).
3. Please send claim to HMC HealthWorks: 5840 Banneker Road, Suite 110, Columbia, MD 21044

MEMBER INFORMATION (The Policy Holder)

Member's Name on ID card: (Last, First, Middle Initial)			Member's Date of Birth		
			MM	DD	YYYY
Member's Street Address: (Check box if new address <input type="checkbox"/>)		City	State		Zip Code
Member's ID:	Member's SSN:	Member's Phone #:	Member's Insurance Group:		

PATIENT INFORMATION

Patient's Legal Name: (Last, First, Middle Initial)			Patient's Date of Birth		
			MM	DD	YYYY
Patient's Relationship to Member: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____				Patient's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

OTHER COVERAGE INFORMATION (If yes, include a copy of your ID card from Medicare or other Insurance Company)

Does patient have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	Part A (Hospital) <input type="checkbox"/> Yes <input type="checkbox"/> No	Part B (Physician) <input type="checkbox"/> Yes <input type="checkbox"/> No	Effective Date of other coverage		
Is the patient covered under any other insurance policy providing health care benefits or services? <input type="checkbox"/> Yes <input type="checkbox"/> No			MM	DD	YYYY
If yes, there is other insurance that is NOT Medicare, please complete a. through c. below:					
a. Name on Other Policy:					
b. Name of Insurance:					
c. Policy Number:					

PATIENT MEDICAL INFORMATION (May be found on itemized Bill or Receipt)

Date of Service / Visit				Diagnosis Code	Procedure Code(s)	Service Provider Information		
1.	MM	DD	YYYY			Name:		
2.	MM	DD	YYYY			Address:		
3.	MM	DD	YYYY			City:	State:	Zip Code:
4.	MM	DD	YYYY			Tax ID #: (Required)	NPI #: (Required)	License Type:

AUTHORIZATION AND SIGNATURE REQUIRED

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any hospital, physician, or other provider which participated in any way in my care and treatment to release to HMC HealthWorks any medical information which they in their judgment deem necessary to the adjudication of this claim.

Signature of Policy Holder:	Date		
X _____	MM	DD	YYYY