COMMUNITY HEALTH CHOICE
COMMUNITY CARES.

Marketplace Medical Claim Form

SECTION 1 SUBSCRIBER CUSTOMER INFORMATION: *Subscriber to complete this section*

A1. SUBSCRIBER'S NAME *(Last Name)*	*(First Name)*	*(M.I.)*	A2. GENDER ☐ M ☐ F	B. DATE OF BIRTH MM DD YYYY
C. SUBSCRIBER'S MAILING ADDRESS *(No., Street)*	*(City)*	*(State)*	*(ZIP Code)*	DAYTIME TELEPHONE # ( )

IS THIS A CHANGE OF ADDRESS?
(Note: address must also be changed with Member Service , if applicable)
☐ YES ☐ NO

D. COMMUNITY ID NUMBER
(on the front of your Community ID card)

SECTION 2 PATIENT INFORMATION: *Complete this section ONLY if the patient is not the subscriber*

A. PATIENT'S NAME *(Last Name)*	*(First Name)*	*(M.I.)*	B. RELATIONSHIP TO THE SUBSCRIBER ☐ Spouse ☐ Child ☐ Other	C. DATE OF BIRTH MM DD YYYY	D. GENDER ☐ M ☐ F

E. PATIENT'S ADDRESS - IF DIFFERENT THAN SUBSCRIBER'S ADDRESS *(No., Street)*	*(City)*	*(State)*	*(ZIP Code)*

F. PATIENT'S COMMUNITY ID NUMBER - *(Community ID Number on the front of your Community ID card)*

SECTION 3 ACCIDENT/OCCUPATIONAL CLAIM INFORMATION:
Complete this section only if you are filing the claim because of an accident or occupational (work-related) illness or injury

A. ACCIDENT OR ILLNESS DUE TO EMPLOYMENT? ☐ YES ☐ NO	B. INJURY DUE TO AUTO ACCIDENT? ☐ YES ☐ NO	C. DESCRIPTION OF HOW ACCIDENT OR WORK-RELATED ILLNESS/INJURY OCCURRED

D. DATE OF ACCIDENT OR BEGINNING OF ILLNESS MM DD YYYY

E. ARE YOU OR YOUR DEPENDENTS FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY INCLUDING AN INSURANCE COMPANY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS ACCIDENT OR ILLNESS?
☐ YES ☐ NO If yes, Name of Third Party/Phone Number: _____

SECTION 4 FAMILY/OTHER COVERAGE INFORMATION:
Complete only if claim is for a dependent and/or other coverage is in effect

A. SPOUSE EMPLOYED? ☐ YES ☐ NO	IF NO, HAS SPOUSE BEEN EMPLOYED DURING LAST 12 MONTHS? ☐ YES ☐ NO	B. NAME OF SPOUSE *(Last Name)*	*(First Name)*	*(M.I.)*	SPOUSE'S DATE OF BIRTH MM DD YYYY

C. NAME OF SPOUSE'S EMPLOYER	ADDRESS OF SPOUSE'S EMPLOYER *(No., Street)*	*(City)*	*(State)*	*(ZIP Code)*	TELEPHONE # ( )

D1. IS THE PATIENT COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? ☐ YES ☐ NO

If yes, provide: NAME OF HEALTH INSURANCE COMPANY	EFFECTIVE DATE OF COVERAGE MM DD YYYY	POLICY NUMBER	TYPE OF PLAN (HMO OR PPO) IF KNOWN

D2. IS THE PATIENT COVERED UNDER MEDICARE? ☐ YES ☐ NO

SECTION 5 CERTIFICATION

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime. For Texas residents, please see the last page of this form.
I certify that the information supplied is true and correct.

SUBSCRIBER'S SIGNATURE X	DATE MM DD YYYY

SECTION 6 PAYMENT INSTRUCTIONS

I authorize Community Health Choice to make payment directly to the health care professional listed on the enclosed bills.

SUBSCRIBER'S SIGNATURE X	DATE MM DD YYYY

IMPORTANT: When the health care professional holds a Community contract, Comunity will always pay the health care professional directly, even if this section is left unsigned. We pay the health care professional at the contracted rate. If you already paid the health care professional for the services you received, you should ask your health care professional to pay you back.

NOTE: Community may disclose the information on this form to other persons and entities. We may do this to process the claim or administer the health plan.