COMMUNITY HEALTH CHOICE
COMMUNITY CARES

Marketplace Medical Claim Form

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)

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.

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INSTRUCTIONS FOR FILING A MEDICAL CLAIM

IMPORTANT

1. **Use this form for all Marketplace Health Insurance medical claims.** You can find the Pharmacy claim forms on Navitus.com.
2. You only need to fill out this form if your health care professional is not filing the claim for you. Even if not part of the Community network (out-of-network), your health care professional still can file the claim for you.
3. If you are filling the form out by hand, use a new printed form instead of a photocopy. That way we can scan your form and process the claim with no delays. Please print clearly in black ink.
4. We must get your claim within 95 days from the date you received the service.
5. Please use a separate claim form for each health care professional, and for each member of your family. You can get a new blank form by calling Member Service at 713-295-6704 or toll-free 1-855-315-5386.
6. To process your claim, we need your Community ID numbers (Section 1, Block D; Section 2, Block F) It's on the front of your ID Community card.
7. We need an itemized bill to process the claim correctly. We cannot accept receipts, balance due statements and cancelled checks in place of the itemized bill.
8. Itemized bills must include:

- Subscriber name
- Date of Service (mm/dd/yyyy)
- Patient name
- Type of service/Procedure code (CPT code)
- Charge service
- Rendering health care professional name/and National Provider Identification number
- Billing health care professional address
- Biling health care professional Tax ID and National Provider Identification PI number
- Diagnosis code (ICD format)

9. We suggest that you make a copy of your bill(s) and your completed claim form for your records.
10. **Important:** We pay covered claims directly to any health care professional with a Community contract. We reserve the right to request other documents, such as medical records, if we need them before processing your claim.
11. If the patient has other health insurance coverage, and that other insurance is primary and Community secondary, we need an Explanation of Benefits (EOB) for this service from the other insurance company when you send the completed form and itemized bill.

MAILING INSTRUCTIONS

- Please don't staple or paper clip the bills to the claim form.
- If you are sending more than one claim in the same envelope, then please use a paper clip to keep the claim form and itemized bills together.
- Send your **completed** claim form and itemized bills to the **Community address**:

Community Health Choice
2636 S Loop W Fwy #125
Houston, TX 77054

Claim form and itemized bills cannot be faxed or emailed.

If you have additional questions, please contact Member Service at 713.295.6704 or toll-free number 1-855-315-5386.

EXPLANATION OF BENEFITS

Once we've processed the claim, you'll receive an Explanation of Benefits (EOB). If applicable, the EOB will explain the charges applied to your deductible (the amount you pay for covered services before your plan begins to pay) and any charges you may owe your health care professional. Please keep your EOB on file in case you need it in the future.

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or 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.

IMPORTANT CLAIM NOTICE

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.