Medical Claim Form

Please return this form to Healthcare Management Administrators (HMA) by mail or fax:

Mail: HMA
Attn: Claims Department
PO Box 85008
Bellevue WA 98015

Fax: 1-866-458-5488

Section 1 – Employee Information		
Name: `		Member ID Number:
Address: ☐ Check this box if this is an address change		
Phone Number:	Date of Birth:	Group Number:
Group Name:		
Marital Status: ☐ Single ☐ Widowed ☐ Legally Separated ☐ Divorced ☐ Married If *Married*, provide your spouse's name: If *Divorced* and the claim(s) are for a dependent child or children: • Is this child (or children) in your permanent custody? ☐ Yes ☐ No • Is there a court order for provision of medical care for this child (or children)? ☐ Yes ☐ No		

Section 2 – Patient Information	
☐ If the employee and patient are the same person, check this box and skip to the next section	
Name:	
Relation to Employee in Section 1: ☐ Employee (self) ☐ Spouse ☐ Child ☐ Other (specify):	
Address:	Phone Number:
	Date of Birth:

Section 3 – Description of Claim	
Provider's Name:	Provider's ID Number*:
*Also known as the National Provider Identifier (NPI). An NPI is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). If you do not know your provider's NPI, we will attempt to look it up. However, please note that your claim may be denied if we cannot verify your provider.	
Description of Illness or Injury:	
Is this a work-related illness or injury? ☐ Yes ☐ No If *Yes*, did you file or will you be filing a claim with Labor & Industries (L&I)? ☐ Yes ☐ No	
If claim is due to an accident, state when, where, and how the accident occurred: • When: • Where: • How:	

HMA

Medical Claim Form

Section 4 – Other Group Health Insurance	
Are you or any of your family members covered by other insurance for medical, dental, or vision benefits? ☐ Yes ☐ No • If *Yes*, who is covered by other group insurance? ☐ Self ☐ Spouse ☐ Dependent(s) ○ If *Spouse*, provide spouse's date of birth: ○ If *Dependent(s)*, list dependent name(s):	
Policyholder's Social Security Number:	
Other Insurance Carrier Name:	
Other Insurance Carrier Address:	
Other Insurance Carrier Phone Number:	
Other Insurance Policy Number:	Effective Date:
Is patient eligible for Medicare benefits? ☐ Yes ☐ No	If *Yes*, enter Medicare eligibility date:

Section 5 – Certification

Caution: Any person who knowingly and with intent to defraud any insurance company, benefits administrator, or other entity: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals information concerning any material fact for the purpose of misleading, commits a fraudulent insurance act.

I certify that the information I provided on this form is true and complete.

_____ _____

(Signature) (Date)

Section 6 – Claims Benefit Assignment

Sign here if you want to receive payment; otherwise, payment will be given to the provider of care. **Note:** Providers who are contracted with a PPO Network that is accessible and utilized by your Health Plan are contractually required to bill your Plan and be paid directly by the Plan for services they provide to you. If you have received services from a provider who is in your Plan's PPO Network, we will be remitting payment to the provider, even if you indicate you want payment to go to you. If you have already paid the provider for your care, you will need to contact them to arrange for a refund, if applicable. Moving forward, please be sure to provide your providers with your insurance card so they can bill your Plan directly.

_____ _____

(Signature) (Date)

Section 7 – Authorization to Release Information

I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.

_____ _____

(Signature) (Date)