Hometown Health Senior Care Plus

MEDICAL CLAIM FORM

Member ID *(See ID Card)* _____ **Group Number** *(See ID Card)* _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Date of Birth (mm/dd/yyyy) _____

Gender ☐ Male ☐ Female

Relationship to Subscriber/Policyholder

☐ Subscriber/Policyholder ☐ Spouse/Partner ☐ Child ☐ Other Dependent

POLICYHOLDER INFORMATION

Complete This Section Only If It Is Different Than The Patient Information.

Subscriber Last Name _____ First Name _____ Middle Initial _____

Home Address _____

City _____ State _____ Zip _____

Phone _____ Date of Birth (mm/dd/yyyy) _____

PROVIDER INFORMATION

This Information Is Required To Process The Claim.
Ask Your Provider For This Information Or Have Them Fill it Out for You.

Provider Name *(or Rendering Provider Name)* _____

Provider Address _____

City _____ State _____ Zip _____

Phone _____ Provider NPI Number _____

Provider Tax Identification Number _____ Group/Facility Name _____

Address Where Services Were Rendered _____

City _____ State _____ Zip _____

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OTHER INSURANCE

Is The Patient Covered By Another Insurance Plan?

☐ ***YES*** ☐ ***NO*** (If yes, please complete the following information.)

Name of Person Carrying Other Insurance

Last Name _____ First Name _____ Middle Initial _____

Date of Birth of Person Carrying Other Insurance (mm/dd/yyyy) _____

Name of Other Insurance Carrier _____

Policy Number _____

Employer Name _____

Effective Date of Other Insurance (mm/dd/yyyy) _____

Cancellation Date of Other Insurance (mm/dd/yyyy) *IF APPLICABLE* _____

Did You Attach an EOB from Medicare or Your Other Insurance?

☐ ***YES*** ☐ ***NO***

ASSIGNMENT OF BENEFITS

☐ **Please Check This Box if You Want Hometown Health to Pay Benefits Directly to the Doctor/Provider.**

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature _____ Date (mm/dd/yyyy) _____