Advantage U

MEDICAL CLAIM FORM

Please fill in all information legibly and completely.

PATIENT NAME		PATIENT'S BIRTHDATE	
MEMBER NAME		PATIENT RELATIONSHIP TO MEMBER	
MEMBER ID#		PHONE NUMBER	
MEMBER HOME ADDRESS	CITY	STATE	ZIP
DATE OF SERVICE	IF INJURED, HOW AND WHERE DID THE ACCIDENT HAPPEN? WORK RELATED? YES____NO____		
IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE PLAN? YES____NO____ POLICY NUMBER: NAME AND ADDRESS OF OTHER INSURANCE COMPANY			

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize any insurance company, prepayment organization, employer hospital, or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable under this or any other plan provider benefits or services. I hereby certify the information provided is correct and to the best of my knowledge.

Signature of Patient or Authorized Representative (Form must be on file) Date

If you have any questions, please call our customer service department at 855-275-0374. Customer service hours are 8:00 a.m. to 8:00 p.m., Mountain Time, 7 days a week. If you are calling from April 1st through September 30th, alternate technologies (for example, voicemail) will be used on weekends and holidays. TTY users, please call 711.

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PROCEDURE FOR FILING A CLAIM

1. Please attach all medical bills relating to the claim(s). Missing or incomplete claim information could delay processing and reimbursement.
    a. Make sure the bills identify the patient and the provider who rendered the services.
    b. All bills should show the date of treatment, description of service and amount of charges.
    c. Procedure Codes and Diagnosis codes should be included.
    d. Proof of payment or receipt must be attached or claim form will be returned.
    e. All statements should have your identification number listed.
    f. Mail to: Advantage U

        PO Box 3117
        Scranton, PA 18505