



DO NOT WRITE IN THE SPACE BELOW



FOR MEDICAL MUTUAL USE ONLY

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> NOT REQUIRED BY MEDICAL MUTUAL <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S ID NUMBER																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
5. PATIENT'S ADDRESS (Street No.)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (Street No.) <input type="checkbox"/> check here if new address.																			
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY			STATE																
ZIP CODE			TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE			TELEPHONE (INCLUDE AREA CODE) ()																
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR NUMBER <div style="text-align: right;">RECIPROCALITY ← N →</div>																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH (MM/DD/YY) SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH (MM/DD/YY) SEX MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO ()					b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. NOT REQUIRED BY MEDICAL MUTUAL SIGNED _____																			
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. ID NUMBER OF REFERRING PHYSICIAN					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO					\$ CHARGES																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. NOT REQUIRED BY MEDICAL MUTUAL																			
1. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER NOT REQUIRED BY MEDICAL MUTUAL																			
2. _____ 4. _____																													
24. A		B		C		D			E		F		G		J		K												
DATE(S) OF SERVICE From To MM DD YY MM DD YY		Place of Service		Type of Service		PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		COB		RESERVED FOR LOCAL USE												
1																													
2																													
3																													
4																													
5																													
6																													
25. FEDERAL TAX ID NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$ NOT REQUIRED BY MEDICAL MUTUAL				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the services were rendered by me or under my direct supervision.) SIGNED _____ DATE _____										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)										33. PHYSICIAN'S/ SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN # _____ GRP# _____									



ATTENTION PROVIDER — FOR FASTER CLAIM PROCESSING REMEMBER:

- The Insured's certificate number (Item #1a) is critical to the timely and accurate processing of this claim. Remember to include any Alphabetic characters which may precede the certificate number.
- The patient's birth date must be listed. (Item #3)
- The insured's full address and zip code are required. (Item #7)
- The group number must be listed. (Item #11)
- Onset date must be completed. (Item #14)
- Diagnosis codes (Items #21 and 24E) and procedure codes (Item #24D) are required.
- The Provider/Supplier SSN or Tax ID # must be completed. (Item #25 or 33)
- SUPER BILLS SLOW DOWN CLAIM PROCESSING.
- ELECTRONIC CLAIMS SUBMISSION SPEEDS CLAIMS PAYMENT.

PLACE OF SERVICE CODES:

- 41 – Ambulance
- 42 – Ambulance-Air/Water
- 24 – Ambulatory Surgical Center
- 25 – Birthing Center
- 53 – Community Mental Health Center
- 61 – Comprehensive Inpatient Rehab. Facility
- 62 – Comprehensive Outpatient Rehab. Facility
- 33 – Custodial Care
- 52 – Day Care/Psy. Part. Hosp.
- 11 – Doctor's Office
- 23 – Emergency Room Hospital
- 34 – Hospice
- 65 – Independent Kidney Disease Treatment Center
- 81 – Independent Laboratory
- 21 – Inpatient Hospital

- 51 – Inpatient Psych. Facility
- 26 – Military Treatment Facility
- 32 – Nursing Care
- 99 – Other Locations
- 22 – Outpatient Hospital
- 12 – Patient's Home
- 56 – Residential Treatment Center
- 72 – Rural Health Clinic
- 31 – Skilled Nursing Facility
- 54 – Specialized/Intermed./Mental TC
- 71 – State or Local Public Health Clinic

- 4 – Diagnostic X-Ray
- 5 – Diagnostic Laboratory
- 6 – Radiation Therapy
- 7 – Anesthesia
- 8 – Assistant at Surgery
- 9 – Other Medical Service
- 0 – Blood or Packed Red Cells
- A – Used DME
- F – Ambulatory Surgical Center
- H – Hospice
- L – Renal Supplies in the Home
- M – Alternate Payment for Maintenance Dialysis
- N – Kidney Donor
- V – Pneumococcal Vaccine
- Y – Second Opinion on Elective Surgery
- Z – Third Opinion on Elective Surgery

TYPE OF SERVICE CODES:

- 1 – Medical Care
- 2 – Surgery
- 3 – Consultation (Inpatient only)

DOE, JOHN
Subscriber Name

123456789
Certificate Number

123ABC
Group Number

Rx **F 19** **4.00/2.00** **D 034** **12-31-92**
Type Chd Age Ded Amt Ag Cd Days Supply Exp Date

ALL Claims should be forwarded to:

**Medical Mutual
P.O. Box 6018
Cleveland, OH 44101-1018**

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NOT REQUIRED BY MEDICAL MUTUAL			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE <input type="checkbox"/> SEX <input type="checkbox"/>	
5. PATIENT'S ADDRESS (Street No.)		6. PATIENT RELATIONSHIP TO INSURED	
CITY		7. INSURED'S ADDRESS (Street No.)	
STATE		8. PATIENT STATUS	
ZIP CODE		CITY	
TELEPHONE (Include Area Code)		STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO INSURED'S POLICY GROUP OR NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS)	
		b. INSURED'S DATE OF BIRTH <input type="checkbox"/> SEX <input type="checkbox"/>	

PATIENT CLAIM FILING INSTRUCTIONS INFORMATION

1. Use this form for filing claims for reimbursement of all eligible Medical and other expenses eligible under MM insurance programs.
2. Complete all Items #1-13 contained in the Patient and Insured Information section including your signature and date. All the information is essential for prompt and accurate processing of your claim(s).
3. If you are submitting the claim, you must either have the provider (physician) of the services complete the Physician/Supplier Information section of this form, or submit an itemized statement (which should include the information noted).
4. The form must include name of patient, date(s) of service, type of service(s) performed, diagnosis, charge(s) and date(s) symptom first appeared.
5. If the Hospital, Physician or other Health Care Provider is submitting the claim, the Provider/Supplier should complete Items #14-33.
6. If you are submitting a drug claim, be sure to include the prescription drug number and drug name, date of purchase, prescribing doctor and amount charged.
7. Balance due statements cannot be processed and will be returned. We need itemized statements for faster processing and better service.
8. Onset date is required (Item #14), otherwise the claim will be returned.
9. To ensure receipt of your EOB and/or reimbursement, please indicate if there is a change in the insured's mailing address. (Item #7)

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)