

MEDICAL and/or VISION CLAIM FORM INSTRUCTIONS

Fax information to: Employer Health Programs (410) 424-4611

Box Number	Instruction
1	Patient Name: Enter the Patient's Name (required)
2	Patient Date of Birth: Enter the Patient's Date of Birth (required)
3	Employee Name: Enter the Employee's Name (required)
4	Patient's Address: Enter the Patient's Address (required)
5	Patient's Sex: Enter the Patient's Sex
6	Employee ID: Enter the Patient's ID Number from the EHP ID card (ID Number starts with 000-) (required)
7	Patient's Relationship: Enter the Patient's relationship to the Employee/Insured
8	Employee Group No.: Enter the Patient's Group Number (starts with E00-) (required)
9	Other Health Coverage: Enter the Other Health Insurance information (if applicable) <i>*for other insurance that is primary, the EOB from that insurance must be enclosed for reimbursement to be considered*</i>
10	Condition: Enter the information pertaining to the condition
11	Insured's Address: Enter the Insured's address information
12	Signature: Sign this field to authorize release of medical information (if needed) in relation to processing the claim.
13	Signature: Sign this field if payment should be made to the Provider (do not sign if payment should be made to the Member)
14	Date of Illness: Enter the date of illness/condition
15	First Date of Treatment: Enter the date first treated for the illness/condition
16	Treatment Dates: Enter the dates if treated previously for same illness/condition
17	Referring Physician: Enter the name of the physician/provider who referred you for this care
18	Facility: Enter the name of the hospital where services were rendered (if not treated in an office)
19	Diagnosis – this is a 3-5 digit code that identifies the illness/condition. This code can be obtained from the provider. At least one diagnosis is required for the claim to be considered for processing. <i>This is also known as an ICD-9 code.</i> (required) Dates of Service – indicate the date(s) services were performed for each procedure (required) Place of Service – indicate if the service was performed in the office, at home, or in a hospital setting. (required) Procedure Code – this is a 5 digit code that identifies the service being performed. This code can be obtained from the provider. Each separate service requires a procedure code. <i>This is also known as a CPT code.</i> (required) Charges – indicate the amount billed for each procedure. (required) Days/Units – indicate the number of services performed. (required) TOS – Not Applicable <i>*if itemized receipt being submitted includes all of this information, there is no need to input on the form as well*</i>
20	Signature of Physician/Supplier: Not required
21	Patient Account Number: if provided on the receipt/bill, enter this information on the claim form. (not required)
22	Total Charge: Enter the total charge amount for all services.
23	Amount Paid: Enter the amount paid to the provider.
24	Balance Due: Enter the amount due to the provider, if applicable (no balance due should be present for member reimbursement to occur)
25	Social Security Number: Not required
26	Employer ID Number: Not required
27	Physician/Supplier's Name, Address: Enter the provider's information (required)

For Member Reimbursement to be considered:

*The itemized receipt must show a zero balance with no patient due amount.

*Balance due statements, receipts that state "Paid in full", payments on account and/or cancelled checks are not acceptable proof of payment.

*Credit Card statements with payment information that matches billed amount(s) are acceptable proof of payment.

*Foreign Services claims/Services outside the United States:

Claims for services outside the United States should be translated into English and converted to US Dollars (conversion rate for specific date of service is to be used) in order to be considered for reimbursement.

