P.O. Box 3430
Carmel, IN 46082-3430
1.866.699.4186

INSTRUCTIONS FOR FILING CLAIM

1. Please fully complete this side of form.
2. Have your doctor complete the back of this form.
3. Mail this form and any other bills to:
   AMERICORPS * VISTA
   Attn: Claims
   P.O. Box 3430
   Carmel, IN 46082-3430
4. Please contact this office if you have any questions.

NOTE: *To expedite the processing of your claim pleasemake sure the diagnosis code, procedure code and providerÕ PIN# are included on the claim and/or receip*

TO BE COMPLETED BY PARTICIPANT

ANSWER ALL QUESTIONS THAT APPLY. SIGN WHERE INDICATED BY

PARTICIPANT INFORMATION

Name ______________________ Date of Birth ______________
First Middle Initial Last Month Day Year

Home Address ______________________________________
Street City State Zip Code

IMPORTANT Identification Number ______________________

INSURANCE INFORMATION

Are any hospital, surgical or medical benefits or services provided under any group, individual, blanket, school, franchise or no-fault auto insurance plan or under any state, federal or other governmental program (i.e. Medicaid)? • Yes • ••No

If "Yes", give the name and address of the insurance company or other organization providing benefits and the policy numbers.

____

Are you covered under Social Security (Medicare) Health Insurance?
• Yes • No
Identification Number: ______________

If "Yes," indicate your coverage by checking the appropriate boxes:
- Hospital Only (Part A)
- Medical Only (Part B)
- Hospital and Medical (Part A & B)

Effective Date: ______________

Are you covered under any other health insurance?
• Yes • No
Identification Number: ______________
Effective Date: ______________

Are you covered under medical assistance (Medicaid)?
• Yes • No
Identification Number: ______________
Effective Date: ______________

Was medical condition related to:

A. Employment • •Yes • No
B. Accident • •Yes • No Date of Accident: ______________

Describe illness, injury or symptoms: ______________________
____
____

Date symptoms first appeared: ______________________

The above information is hereby certified to be true and complete. I agree to reimburse my health plan if this claim for sickness/injury is compensable under Medicare-Medicaid, the Worker's Compensation Act or similar law, if benefits excluded by the provisions of the contract are paid, if such claim is settled or compromised or in the event of recovery from a third party.

Date	Participant's Signature

PERMISSION TO OBTAIN INFO

I permit any physician, pharmacist, hospital or other health care provider, any insurer, prepayment organization or other health plan provider to give my health plan or its representative any medical information about the patient listed above, including information about physical and mental health, medical history and drug or alcohol use. This information will be used to evaluate claims for benefits.

This authorization will remain in effect until all matters relating to these claims are concluded. A copy of this authorization will be as valid as the original. I understand that I may receive a copy of this authorization if I ask for one in writing.

Date	Participant's Signature

TOTAL CHARGES submitted with this form: $ Issue Payment to:••• •Participant • Provider

HEALTH CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

TYPE OR PRINT ❑ MEDICARE ❑ MEDICAID ❑ CHAMPUS ❑ OTHER

PATIENT & PARTICPANT INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*
2. PATIENT'S DATE OF BIRTH
3. PARTICIPANT'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, zip code)*
5. PATIENT'S SEX ❑ Male ❑ Female
6. PARTICIPANT'S I.D. NO. or **MEDICARE NO.** *(Include any letters)*
7. PATIENT'S RELATIONSHIP TO PARTICIPANT
   SELF SPOUSE CHILD OTHER
8. PARTICIPANT'S GROUP NO. *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE — Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
10. WAS CONDITION RELATED TO
    A. PATIENT'S EMPLOYMENT ❑ Yes ❑ No
    B. AN AUTO ACCIDENT ❑ Yes ❑ No
11. PARTICIPANT'S ADDRESS *(Street, city, state, zip code)*
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
    I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of Benefits Either to Myself or to the Party Who Accepts Assignment Below.
    SIGNED *DATE*
13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW*
    SIGNED (Participant or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ◀ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ❑ Yes ❑ No
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY
    FROM THROUGH
    DATES OF PARTIAL DISABILITY
    FROM THROUGH
19. NAME OF REFERRING PHYSICIAN
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITAL DATES
    ADMITTED DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ❑ Yes ❑ No CHARGES
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE
    1.
    2.
    3.
    4.

24.

A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY:)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D DIAGNOSIS CODE	E CHARGES	F

25. SIGNATURE OF PHYSICIAN OR SUPPLIER
    SIGNED DATE
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) ❑ Yes ❑ No
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NUMBER
    I.D. NO.
32. YOUR PATIENT'S ACCOUNT NO.
33. YOUR EMPLOYER I.D. NO.

*PLACE OF SERVICE CODES

1 - (IH) - INPATIENT HOSPITAL
2 - (OH) - OUTPATIENT HOSPITAL
3 - (O) - DOCTOR'S OFFICE
4 - (H) - PATIENT'S HOME
5 - DAY CARE FACILITY (PSY)
6 - NIGHT CARE FACILITY (PSY)
7 - (NH) - NURSING HOME
8 - (SNF) - SKILLED NURSING FACILITY
9 - AMBULANCE
O - (OL) - OTHER LOCATIONS
A - (IL) - INDEPENDENT LABORATORY
B - OTHER MEDICAL/SURGICAL FACILITY