Medical Claim Form

What is this form for?

Use this Compass Health Administrators Claim form to request payment for eligible care you have already received.

Did you know?

You receive a higher benefit if you use an in network provider. This can be especially cost effective when receiving ongoing services such as physical therapy or durable medical equipment.

How to submit a claim:

- Complete all fields of this form.
- Make a copy of this claim form, claim details and receipt(s) to keep for your records.
- Send the claim as soon as you can following services being rendered. Most plans require that services be submitted within 90 days of the date you received them.
- Verify that your member ID and the provider or facility details are clear and complete on the claim and on the receipt(s). This will help us process your claim quickly.
- Include an itemized bill of the services from your provider. This is usually separate from the receipt of payment. The details from the provider should include procedure codes and diagnosis codes for the services you received, billed amounts for each service, the provider's TIN or NPI number, and their billing and service addresses.
- **Mail your form with the claim details and receipt(s) to the address on the back of your health plan ID card.**

What happens next?

After processing your claim, you will receive an explanation of benefits (EOB). The EOB we send to you will explain how the claim was processed including details about any charges applied to your deductible (amount you pay for covered services before your plan begins to pay) and any amount you may owe the provider. Please keep your EOB on file in case you need it in the future. You can also access your claim information at our website www.vch-compass.com.

EMPLOYEE/SUBSCRIBER INFORMATION

Employee Name (Last, First, Middle Initial) | Member ID / Group No. | Employee SSN - -

Employee Home Address (Street, City, State, Zip Code)

Employee Date of Birth / / | Employee Phone # ( ) - | Gender ❑ Male ❑ Female

Name and Address of Employer

PATIENT INFORMATION
(If different from Employee/Subscriber)

Patient Name (Last, First, Middle Initial) | Member ID / Group No. | Date of Birth / /-

Home Address (Street, City, State, Zip Code)

Employee Phone # ( ) - | Gender ❑ Male ❑ Female | Relationship to Employee/Subscriber ❑ Spouse/Partner ❑ Child ❑ Other

Is Dependent Employed? ❑ Yes ❑ No | If Yes, Name of Dependent Employer

OTHER INSURANCE INFORMATION

Is Patient Covered by Another Insurance Plan ❑ Yes ❑ No (If Yes, please complete the following information)

Name of Person Carrying Other Insurance (Last, First, MI) | Date of Birth / /

Other Carrier Name | Policy/Group Number | Employer Name

PROVIDER INFORMATION

PROVIDER NAME | PROVIDER TIN

PROVIDER ADDRESS

CITY | STATE | ZIP CODE

ACCIDENT INFORMATION

DATE OF ACCIDENT / / | TYPE OF ACCIDENT ❑ Work ❑ Auto ❑ Other

Briefly describe how accident occurred

_____

_____

_____

❑ Check here if you would like Compass Administrators to pay benefits directly to the doctor/provider (applies to non-contracted providers only).

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 criminal penalties.

Signature: _____ Date: _____