First Health A Coventry Health Care Company	First Health Preferred Provider Network	MAIL FORM TO: **HealthSmart** 3320 West Mark et Street Suite 100 Fairlawn Ohio 44333 Phone 800.203.4720 • Fax 806.473.3136	ADVENT SYNDICATE 780

TO BE COMPLETED BY INSURED PERSON

1. School Name: _____ Policy #: _____
2. Insured Person: _____ Group #: _____
3. Local Address: _____
4. Home Address: _____
5. Date of Birth: ____/____/____ Local Phone: _____ Home Phone: _____
6. Are you an OPT Student? ☐ Yes ☐ No 7. What type Visa do you hold? _____
8. Patient Status: ☐ Male ☐ Female ☐ Single ☐ Married Plan Member ID _____

Is this Claim for a dependent? ☐ Yes ☐ No If yes, give name: _____

Relationship: _____ Date of Birth: _____

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

9. Is this claim the result of an accident? ☐ Yes ☐ No If yes, give date of accident: ____/____/____ Time of Accident: _____
10. Is this claim the result of a work-related injury? ☐ Yes ☐ No

Is this claim the result of an auto accident? ☐ Yes ☐ No

Is this claim the result of sports participation? ☐ Yes ☐ No If "yes" ☐ intercollegiate ☐ intramural ☐ club ☐ other

11. Where did the accident occur? _____

How the accident did happen? _____

COMPLETE THIS SECTION FOR SICKNESS CLAIM

12. Name of physician: _____ Date of initial service: ____/____/____
13. Description of Illness: _____
14. Has the patient been treated for the above condition(s) in the last 12 months? ☐ Yes ☐ No

If "yes" give condition(s) treated for and date(s) of treatment: _____

COMPLETE THIS SECTION FOR ALL CLAIMS (ACCIDENT OR SICKNESS)

15. Is patient covered for benefits by any Group Health, Employer, Union, Welfare Plan or Parent Health Plan? ☐ Yes ☐ No

Other coverage provided through: Name of Person _____ Relationship _____

If answered "yes" please complete the following:

Insurance Co. or Benefit Plan _____ Employer or Sponsor _____

Address _____ Address _____

Telephone: _____ Telephone _____

Policy # _____ Please include a photocopy of other plan identification card, if available

COMPLETE THIS SECTION IF HEALTH CENTER REFERRAL IS NEEDED

16. Date seen at health center ____/____/____/ Authorized signature _____

I did not go to the health center because: (check one) ☐ I was not in the area ☐ it was an emergency ☐ the health center was closed

17. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.

NEW YORK*: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Insured Person _____ Date _____ 20 _____

Patient's or Authorized Person's Signature _____ Date _____ 20 _____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)

Authorization to Pay Benefits: I hereby authorize payment directly to: any physician or provider of service for which I am submitting attached billings and charges.
For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization

Signature

CLAIM FORM FRAUD STATEMENT - FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA: WARNING :Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TENNESSEE and VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.