

MEDICAL CLAIM FORM

luminare healthSM

MAIL TO:

**Address Indicated On
Your Identification Card**

Instructions:

1. Please complete all sections
2. All itemized bills MUST be attached and include: Patient's name, Provider's name, diagnosis, dates of services and charge amount.
3. If you or a dependent are covered by another Plan (including Medicare), please submit the bill to the Primary Plan first. Then send our office a copy of the Explanation of Benefits along with the bill.

EMPLOYEE INFORMATION

Name (First, MI, Last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Member Number
Home Address	City	State	Zip	
Employer:	Date of Hire	Occupation	Date Last Worked	

PATIENT INFORMATION

Patient Name (First, Middle, Last)		Relationship	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate
Is the Patient Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the Patient a Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, How Many Hours?	Date Last Attended?	Name and Address of School
Nature of Illness		Name, Address and Phone No. of Doctor Seen For This Illness		

IF CLAIM IS BASED ON AN ACCIDENT, COMPLETE THE FOLLOWING

Date and Time of Accident	Was Accident Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Place	How It Happened
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SPOUSE INFORMATION

Name (First, MI, Last)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Soc. Sec. No.
Spouse's Employer Name	Address	Phone No.		

OTHER INSURANCE INFORMATION

Do You or Your Dependents Have Other Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage? <input type="checkbox"/> Single <input type="checkbox"/> Family	Type of Plan? <input type="checkbox"/> Group Health Plan <input type="checkbox"/> Government Plan <input type="checkbox"/> Medicare <input type="checkbox"/> Other		
Name of Person Covered by Other Insurance	Group Number	Soc. Sec. No.	Benefits <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other	
Name and Address and Phone No. of Other Insurance Company				

INFORMATION ABOUT YOUR OTC COVID-19 TEST	
<p>To be eligible for reimbursement, you must submit:</p> <ul style="list-style-type: none"> A separate claim form for each member for whom the at-home test is purchased on or after Jan. 15, 2022. Proof Of Payment such as the Original receipt(s) for at-home test(s), showing the amount paid and the test(s) purchased. The UPC/barcode information from the at-home test(s) <p>If we don't receive the required information, your request will not be processed.</p>	
<p>Name of the FDA authorized test(s) purchased (e.g., BinaxNOW, QuickVue, Intelliswab, etc.)</p> <p>Please attach proof of purchase/receipt</p>	<p>Purchase date(s)</p> <hr/> <p>How many tests are you submitting for reimbursement? (some kits include more than one test – enter the total number of tests)</p>
<p>ATTESTATION: I attest that the over the counter COVID-19 test(s) I am submitting for reimbursement will not be used for employment testing purposes, nor sold for profit. When I sign 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 civil penalties.</p>	
	<p>_____</p> <p style="text-align: center;">MEMBER SIGNATURE</p> <p style="text-align: right;">_____</p> <p style="text-align: right;">DATE</p>
<p>AUTHORIZATION TO RELEASE INFORMATION -- I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to Luminare Health for any oral or dental observation, treatment, services, or benefits rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original</p>	
	<p>_____</p> <p style="text-align: center;">PATIENT'S SIGNATURE (PARENT IF MINOR)</p> <p style="text-align: right;">_____</p> <p style="text-align: right;">DATE</p>
<p>AUTHORIZATION TO PAY BENEFITS TO PROVIDERS -- I hereby authorize payment of benefits to any providers of service rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original</p>	
	<p>_____</p> <p style="text-align: center;">PATIENT'S SIGNATURE (PARENT IF MINOR)</p> <p style="text-align: right;">_____</p> <p style="text-align: right;">DATE</p>