Use this form to submit claims for out-of-network services

Group Health Claim Form

"NOTICE to all parties completing this form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts."

HOW TO PRESENT A CLAIM (Please read carefully)

1. **Both** sides of this form must be completed — this side by the physician or supplier, the reverse side by the employee or member. A separate form is required **each** time a claim is submitted and for **each** family member submitting a claim. To avoid delay, answer **all** questions, sign and date the Certification of Statements and the Patient's Authorization sections on the back of this form.
2. If the physician or supplier does not complete the section below, please attach itemized bills showing the following:
   - Name, address and Tax ID Number of physician or provider of service
   - Name of patient
   - Date(s) service(s) rendered
   - Charge(s) made
   - Nature of illness or injury (**Be certain** your physician indicates the appropriate diagnosis code(s) from the current revision of the International Classification of Diseases, Clinical Modification (ICD-CM)
   - Type of service(s) (**Be certain** your physician indicates the appropriate code from the most recent edition of the Current Procedural Terminology (CPT) or HCFA Common Procedural Coding System (HCPCS))
   - Bills for drugs and medicines should show:
     - Name and address of pharmacy
     - Name of person for whom the medicine was prescribed
     - Date(s) of purchase(s)
     - Charge for each prescription
     - Prescription number(s) and nature of medication(s)
3. **Please check all bills for accuracy. Do not present cancelled checks or cash register receipts as they do not contain the information needed to process a claim. Please follow the instructions in No. 2 above.**
4. If you wish to retain copies of your bills, they should be obtained before your claim is submitted.
5. If you or your dependent have received consideration of these expenses by another group plan, please attach a copy of your statements of payment or rejection from that plan.
6. If you or your dependent are eligible for Medicare, please attach a copy of your statements of payment or rejection for these expenses received from Medicare Part A and Part B.
7. Send the completed claim form, with bills attached, to:

   The Prudential
   Houston Group Health Claim
   P.O. Box 27718
   Houston, TX 77227-7718

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

Name of Patient Last First Middle Initial	Name of Employee or Member Last First Middle Initial

Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Mo.	Day	Yr.	Date Patient First Consulted You for this Condition	Mo.	Day	Yr.	Has Patient ever had Same or Similar Symptoms? ☐ Yes ☐ No

Date(s) of Service	Units or Days	Place of Serv-ice *	ICD-CM Diagnosis Code	CPT/HCPCS Procedure Code	MOD	MOD	Description of supplies or, if needed, additional medical service information	Charges

I Authorize Payment of Medical Benefits to Undersigned Physician or Supplier for Service(s) Described

Patient's Signature, (if minor child, parent's signature) Date

Physician's or Supplier's Name, Address, Zip Code & Telephone No.	Your Patient's Account No.	Total Charge	Amount Paid	Balance Due
	Federal Tax Reporting No. *(IRS requirement)* ☐ SSN ☐ EIN/TIN	Signature of Physician or Supplier Signed Date		

*Place of Service Codes:
- 1 - Inpatient Hospital
- 2 - Outpatient Hospital
- 3 - Doctor's Office
- 4 - Patient's Home
- 5 - Day Care Facility (PSY)
- 6 - Night Care Facility (PSY)
- 7 - Nursing Home
- 8 - Skilled Nursing Facility
- 9 - Ambulance
- O - Other Locations
- A - Independent Laboratory
- B - Other Medical/Surgical Facility

Group No.	Branch #

TO BE COMPLETED BY EMPLOYEE OR MEMBER

Name and Home Address (Please print) Last	First	Middle Initial	Social Security Number	☐ Male ☐ Female	Employment status ☐ Active ☐ Retired	Date of Birth Mo. Day Yr.
Number	Street	City	State	Zip Code	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Home phone #	Name, address, and phone # of employee's employer

Please indicate Spouse's name	Spouse's Social Security #	Spouse's Date of Birth Mo. Day Yr.	Is your Spouse employed? ☐ Yes ☐ No

Spouse's employer's name, complete address and phone #

Is patient also covered by any Group Health Plan or HMO provided by:

a. Another employer, union, trade association, school or arrangement of coverage for individuals in a Group? ☐ Yes ☐ No

b. Medicare/Medicaid, or any other federal, state, or governmental agency? ☐ Yes ☐ No

If either is answered "Yes," please indicate in "Remarks" the policy number, plan provider and the name and address of the employer, union, trade association, school, governmental agency, or any other arrangement for Group coverage.

Was illness or injury due, in any way, to the patient's occupation? ☐ Yes ☐ No If "Yes," please describe in "Remarks."

Is claim due to an accident? ☐ Yes ☐ No If "Yes," give date and explain in "Remarks" where and how injury occurred.

a. If auto accident, circle whether patient was the owner, driver, passenger or pedestrian and whether vehicle was private passenger, taxi, bus, truck, or other. Also, furnish name of automobile owner, insurance company and policy number, and state in which accident occurred.

b. For all accidents: Does the patient expect to receive, or has the patient received, payment for these expenses from another source as the result of a lawsuit or settlement? ☐ Yes ☐ No If "Yes," please provide details in "Remarks."

Remarks:

Dependent Information/Complete only if Patient is a Dependent

Name of Dependent	Relationship: ☐ Spouse ☐ Child ☐ Other (specify):	☐ Male ☐ Female	Date of Birth Mo. Day Yr.	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If claim is for dependent child 19 or older:
Is child enrolled as full-time student? ☐ Yes ☐ No
Is that child employed? ☐ Yes ☐ No

Name and complete address of school or employer and Dependent's Social Security Number

If claim is for dependent child:
Are the legal parents divorced or separated? ☐ Yes ☐ No Name of parent with custody ______
Is there a court decree establishing financial responsibility for medical expenses for this child? ☐ Yes ☐ No
Name of parent with responsibility ______
Does this parent have medical coverage for dependents? ☐ Yes ☐ No Name and address of carrier:

Be sure to complete for each claim Nature of illness	Number of Bills Attached	Covers Period From Mo. Day Yr.	To Mo. Day Yr.	Total Charges

Certification of Statements
I certify that all the above statements are correct and that the attached bills represent actual services, dates, and fees charged to me or my eligible dependents.

Employee's or Member's Signature Date

Patient's Authorization
To all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (this includes any insurers, Blue Cross-Blue Shield and prepaid health plans): I agree that Prudential, or its representatives, may see, or get a copy of, all medical, mental and dental care, drug or alcohol treatment, prescribed drug, employment and insurance coverage records which pertain to:

(Print Name of Patient) ______

This information is for the sole use of Prudential, or the group contract holder who will process the claim. Unless a law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing. The authorization may be used for no longer than the duration of the claim or one year after the date it is signed unless revoked in writing. A photocopy of this form is as valid as the original. The person who signs this form may have a copy of it upon request.

Patient's Signature (If a minor child, parent's signature) Date