



**AMERIHEALTH CLAIM FORM**

(see reverse side for instruction)

Please Mail To:  
**AMERIHEALTH INSURANCE COMPANY**  
 P.O. BOX 41574  
 PHILADELPHIA, PA 19101-1574

<b>MEMBER/PATIENT</b>	I. MEMBER'S NAME (First, Middle, Last)		IDENTIFICATION NO.	GROUP NO.
	PRESENT ADDRESS-STREET <input type="checkbox"/> NEW ADDRESS		CITY	STATE ZIP CODE
	PATIENT'S NAME (First, Middle, Last)	RELATIONSHIP OF PATIENT TO MEMBER <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Handicapped dependent <input type="checkbox"/> Other		SEX BIRTH DATE <input type="checkbox"/> M <input type="checkbox"/> F _____/_____/____

<b>OTHER INSURANCE</b>	II. <input type="checkbox"/> Does the PATIENT have additional health insurance? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, complete Part II:			
	POLICYHOLDER'S NAME		BIRTH DATE _____/_____/____	EMPLOYMENT STATUS OF POLICYHOLDER <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Effective Date: ____/____/____
	Relationship of Policyholder to Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		Other Insurance Carrier's Name	Identification No. Effective Date _____/_____/____
	TYPE(S) OF COVERAGE <input type="checkbox"/> Hospitalization <input type="checkbox"/> Medical-Surgical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug <input type="checkbox"/> Major Medical <input type="checkbox"/> Other (specify) _____			
	CONTRACT COVERS <input type="checkbox"/> Policyholder Only <input type="checkbox"/> Policyholder and Spouse <input type="checkbox"/> Policyholder and Child(ren) <input type="checkbox"/> Family			

<b>PATIENT'S CONDITION</b>	III. <input type="checkbox"/> DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:		
	Type of Injury or Illness	Name of Doctor Treating Injury/Illness	Date of First Symptoms
	A. _____	_____	_____/_____/____
	B. _____	_____	_____/_____/____
	<input type="checkbox"/> WERE SERVICES RELATED TO HOSPITALIZATION? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, please give: Date of Admission ____/____/____ Date of Discharge ____/____/____ Hospital Name _____ Admitting Physician _____ <input type="checkbox"/> WERE EXPENSES DUE TO AN ACCIDENT? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, give type/place of accident: Give date of accident ____/____/____ <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> IS THIS CLAIM FOR PRESCRIPTION DRUGS? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, please give: Pharmacy Name _____ Address _____ NDC Number (obtain from Pharmacist): _____ - _____ - _____		

<b>AUTHORIZATION</b>	IV. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to AmeriHealth all medical or other information requested for the processing of this claim. I hereby agree to reimburse AmeriHealth in full should this claim be incorrectly paid. 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.			
	MEMBER SIGNATURE	DATE	(AREA CODE) HOME PHONE	(AREA CODE) WORK PHONE

## INSTRUCTIONS

If your provider is participating in AmeriHealth, the provider will submit a claim for you. This claim form should only be submitted when you use a non-participating AmeriHealth provider who does not submit a claim for you.

1. Please attach itemized bills to this claim form. These bills should include the following information:
  - Name, address, and telephone number (on official bill head) of the PROVIDER rendering the service or supplying the item.
  - PATIENT'S full name
  - DESCRIPTION of each service rendered or item supplied
  - DATE AND AMOUNT CHARGED for each service rendered or item supplied
  - DIAGNOSIS of ailment
2. Please be sure that a PHYSICIAN'S MEDICAL CERTIFICATION accompanies bills for:
  - Purchase or rental of medical equipment
3. When you are submitting expenses for more than one family member, please use a SEPARATE claim form for each person.
4. Please complete the claim form carefully, and be sure to include the information requested above. This will help to avoid unnecessary delays in processing your claim.
5. Prescription drug purchases made at network pharmacies do not require you to submit a claim form. The pharmacist will file the claim for you, and any resulting benefit payments will be made directly to you. If you purchase your prescription drug at a non-network pharmacy, you may still be entitled to reimbursement for a portion of your prescription drug expenses by completing Section III of this claim form. Be sure to include itemized receipts for each prescription. Remember to ask your pharmacist for the NDC number of the drug you purchase, and record that number in Section III on the front of this form.