



MEDICAL CLAIM FORM

Please return this form to Healthcare Management Administrators (HMA) by mail or fax:

Mail: HMA
 Attn: Claims Department
 PO Box 85008
 Bellevue WA 98015

Fax: 1-866-458-5488

SECTION 1 – EMPLOYEE INFORMATION		
Employee Name:		Member ID Number:
Address:		Is this an address change: <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone Number: ()	Employee's Date of Birth:	Group Name and Group Number:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Married If married, provide name of spouse:		
If you are divorced and the claim(s) are for a dependent child or children, please answer these questions: Is this child (or children) in your permanent custody? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there a court order for provision of medical care for this child (or children)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
SECTION 2 – PATIENT INFORMATION		
Patient Name:	Patient is: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other If other, specify:	
Address:		
Phone Number: ()	Patient's Date of Birth:	
If claim(s) are for a dependent over age 19, is the dependent a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach proof of student status and identify it here:		
SECTION 3 – DESCRIPTION OF CLAIM		
Description of Illness or Injury:		
Is this a work-related illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did you file or will you be filing a claim with Labor & Industries (L&I)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If claim is due to an accident, state when, where, and how the accident occurred:		

SECTION 4 – OTHER GROUP HEALTH INSURANCE

Are you or any of your family members covered by other insurance for medical, dental, or vision benefits?
 Yes No

Check only those covered by other group insurance: Self Spouse Dependent(s)

If spouse, provide date of birth: _____

If dependent(s), list name(s): _____

Name and address of other insurance carrier:

Phone number of other insurance carrier:	Policy Number:	Effective Date:
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Is patient eligible for Medicare benefits? Yes No

If yes, enter date of eligibility: _____

Patient's Social Security Number: _____

SECTION 5 – CERTIFICATION

Caution: Any person who knowingly and with intent to defraud any insurance company, benefits administrator, or other entity: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals information concerning any material fact for the purpose of misleading, commits a fraudulent insurance act.

I certify that the information I provided on this form is true and complete.

(Signature) (Date)

SECTION 6 – CLAIMS BENEFIT ASSIGNMENT

Sign here if you want to receive payment; otherwise, payment will be given to the provider of care.

(Signature) (Date)

SECTION 7 – AUTHORIZATION TO RELEASE INFORMATION

I expressly authorize any provider of care to provide Healthcare Management Administrators with any records concerning me or any member of my family for whom benefits or services have been claimed.

(Signature) (Date)