

Claim Form

Not to be used for Pharmacy or Dental Claims

Mail To: Preferred Care, Inc.

P.O. Box 1235

Frederick, MD 21702-0235

Toll Free: 888-264-1512



This form can be used for all medical plans.

This form only needs to be completed if the provider is not submitting the claim on your behalf. Out of network claims can be submitted by the provider if the provider is able and willing to file on your behalf.

Please refer to reverse side for instructions.

INSURED INFORMATION: Insured complete this section							
A. INSURED'S NAME (Last Name, First Name, Middle Initial)					B. Date of Birth MM DD YYYY		
C. INSURED'S MAILING ADDRESS (No., Street)		(City)	(State)	(Zip Code)	DAYTIME TELEPHONE# ()		
IS THIS A CHANGE OF ADDRESS? (Note: address must also be changed with Group) <input type="checkbox"/> YES <input type="checkbox"/> NO		D. ID NUMBER OR INSURED'S SOCIAL SECURITY #		E. ACCOUNT NUMBER			
F. GROUP NAME			G. Group Status <input type="checkbox"/> Member <input type="checkbox"/> Disabled <input type="checkbox"/> Other _____		* Effective Date MM DD YYYY		
PATIENT INFORMATION: Complete only if patient is other than Insured							
A. PATIENT'S NAME (Last Name, First Name, Middle Initial)			B. RELATIONSHIP TO INSURED		C. DATE OF BIRTH MM DD YYYY		D. SEX <input type="checkbox"/> M <input type="checkbox"/> F
D. PATIENT'S ADDRESS-IF DIFFERENT THAN INSURED'S ADDRESS (No., Street)			(City)	(State)	(Zip Code)		
F. AT THE TIME MEDICAL SERVICE WAS PROVIDED WAS THE PATIENT: <input type="checkbox"/> EMPLOYED FULL-TIME <input type="checkbox"/> STUDENT FULL TIME <input type="checkbox"/> N/A							
ACCIDENT/OCCUPATIONAL CLAIM INFORMATION: Complete only if claim is a result of an accident or occupational (work related) illness/injury							
FAMILY/OTHER COVERAGE INFORMATION: Complete only if claim is for a dependent and/or other coverage is in effect							
A. SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF NO, HAS SPOUSE BEEN EMPLOYED DURING THE LAST 12 MONTHS <input type="checkbox"/> YES <input type="checkbox"/> NO		B. NAME OF SPOUSE (Last Name, First Name, M.I.)			B. DATE OF BIRTH MM DD YYYY
C. NAME OF SPOUSE'S EMPLOYER		ADDRESS OF SPOUSE'S EMPLOYER (No., Street)		(City)	(State)	(Zip)	Telephone # ()
D1. IS THE PATIENT COVERED UNDER ANOTHER EMPLOYER GROUP HEALTH INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, provide:							
NAME OF HEALTH INSURANCE COMPANY		EFFECTIVE DATE OF COVERAGE MM DD YYYY		POLICY NO.	TYPE OF PLAN (HMO OR PPO) IF KNOWN		
D2. IS THE PATIENT COVERED UNDER MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO							
IF YES TO D1 OR D2, AND THE OTHER INSURANCE IS PRIMARY, ENCLOSE A COPY OF THE EXPLANATION OF BENEFITS (EOB) WITH THIS FORM AND THE ITEMIZED BILL(S).							
CERTIFICATION							
Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning material fact thereto, commits a fraudulent insurance act which is a crime. For residents in the following states, please see the last page of this form: Alaska, Arizona, California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas and Virginia.							
I certify that the information supplied is true and correct.							
INSURED'S SIGNATURE X					DATE MM DD YYYY		
PAYMENT INSTRUCTIONS							
I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s)							
If an indemnity plan is selected benefits will be made on an expense basis up to the indemnity benefit amount							
INSURED'S SIGNATURE X					DATE MM DD YYYY		
NOTE: The information provided on this form may be disclosed to other persons or entities, including my Plan Sponsor, for the purpose of processing this claim and performing health plan administration							

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

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

IMPORTANT CLAIM NOTICE

Alaska Residents: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona Residents: 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.

California Resident: Any person who knowingly presents 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 Residents: 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 settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provide by the applicant.

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

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

(2) All claim forms shall contain a statement in a form approved by the Office of Insurance that clearly states in substance the following: "Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire Residents: 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 Residents: Any person who knowingly and with intent to defraud any insurance company or other persons, files a 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, subject to criminal prosecution and civil penalties.

New York Residents: 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.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Residents: WARNING: 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.

Pennsylvania Residents: 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.

Tennessee Residents: 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 Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and maybe subject to fines and confinement in state prison.

Washington Residents: 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.