Patriot Healthcare

Member Claim Form

ALL INFORMATION MUST BE PROVIDED -- PRINT IN INK OR TYPE AND MAIL TO: PATRIOT HEALTHCARE, PO BOX 2000, EXETER NH 03833-2000

1. PATIENT'S NAME (Last) (First) (M.I.)	2. SEX ☐ MALE ☐ FEMALE	3. DATE OF BIRTH MO. DAY YR.
4. STREET ADDRESS	5. HOME PHONE NO. WORK PHONE NO.	6. GROUP NUMBER
7. CITY, STATE, ZIP CODE	8. SOCIAL SECURITY NO.	9. SUBSCRIBER'S ID NUMBER
10. PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDENT OTHER	11. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT ☐YES ☐ NO ACCIDENT? ☐YES ☐ NO	12. DATE OF ACCIDENT OR INJURY OCCURRED MO. DAY YR.

13. IS THE PATIENT COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY? (If yes, indicate the name of the company and identification number) ☐ YES ☐NO COMPANY NAME____________ IDENIFITICATION NUMBER ____________	14. BILLING HOSPITAL, DOCTOR, SUPPLIER NAME ____________ STREET____________ CITY ____________STATE ________ ZIP ________
15. NAME(S) OF ILLNESSES OR INJURIES FOR WHICH THE PATIENT WAS TREATED	DIAGNOSIS CODE BILLING PROVIDER I.D. PAY CODE
1.	EIN/SSN I.D.
2.	16. REFERRING DOCTOR (DR WHO REFERRED PATIENT FOR TREATMENT) NAME
3.	STREET
4.	CITY STATE ZIP

TYPE OF BILL

17. DATE OF SERVICE (Mo./Day/Yr.) FROM TO	18. PLACE OF SERVICE	REVENUE CODE	PROCEDURE CODE	19. DESCRIPTION OF SERVICE	DIAGNOSIS CODE	20. CHARGES	UNITS	ATTENDING PHYSICIAN I.D.

*EXPLANATION OF BLOCK 18: PLEASE INDICATE ONE OF THE FOLLOWING CODES TO IDENTIFY WHERE EACH SERVICE WAS PROVIDED.

DOCTOR'S OFFICE……………………..…….1 INDEPENDENTLAB……………………………..6
PATIENT'S HOME ………………………...2 HOME HEALTH AGENCY…...…………………7
HOSPITAL/INPATIENT (BED PATIENT)..3 AMBULANCE……………………………………8
NURSING HOME (SKILLED FACILITY)...4 DME SUPPLIER………………………………….9
HOSPITAL OUTPATIENT (ER)…………...5 PHARMACY (M&S SUPPLIES/DME)………….P

TOTAL SERVICES

TOTAL CHARGE

21. ATTENDING DOCTOR (DOCTOR WHO TREATED PATIENT)

NAME ____________

STREET ____________

CITY____________ STATE________ ZIP________

22. I AUTHORIZE THE RELEASE TO PATRIOT HEALTHCARE OF ANY INFORMATION NECESSARY TO PROCESS THIS CLAIM.

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SIGNATURE OF SUBSCRIBER DATE

THE PERSON SIGNING THIS FORM IS ADVISED THAT THE WILFUL ENTRY OF FALSE OR FRAUDULENT INFORMATION RENDERS YOU LIABLE TO PROSECUTION.

Form no. 016a Rev (3/05)

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SUBMISSION INSTRUCTIONS

- Place itemized bill, receipt or Explanation of Benefits behind the Subscriber Claim Form. Send the completed Subscriber Claim Form and itemized bill, receipt or Explanation of Benefits to:

    - Patriot Healthcare
    - Attn: Claims Dept
    - P O Box 2000
    - Exeter, NH 03833-2000

- This form is to be completed by the subscriber; accompanied by a copy of a hospital's UB-92 billing form (when hospital is outside of New Hampshire), or a doctor's or supplier's itemized bill or receipt, or an Explanation of Benefits from another health insurance plan or Medicare, and submitted to Patriot Healthcare for benefit consideration.

- Submit a completed Subscriber Claim Form for each patient with an itemized bill, receipt or Explanation of Benefits for that patient, as soon as provider's (one provider per claim form) itemized bill, receipt or an Explanation of Benefits is received.

- **EACH ITEMIZED BILL OR RECEIPT MUST CONTAIN:**

    - Name and address of hospital, doctor or supplier
    - When the itemized bill or receipt lists the names of several doctors or suppliers, please circle the name and address of the individual who treated the patient
    - Patient's name
    - Date of each service
    - Place of each service
    - Complete description of each service
    - Charge for each service
    - Additional information required for:
    - Ambulance bills—Destination transported and mileage accrued
    - Durable Medical Equipment bills—Purchase price whether rented or purchased. If rented, rental period, start and end date
    - Prescription drugs—Submit on Prescription Drug claim Form
    - Private duty nurse—Degree pf mires and hours worked (day and night)

- **PLEASE RETAIN COPIES OF ITEMIZED BILLS, RECEIPTS OR EXPLANATION OF BENEFITS FOR YOUR RECORDS AS THEY WILL NOT BE RETURNED TO YOU**

- **DATA BLOCKS REQUIRING SPECIAL ATTENTION**

    - **BLOCK 10**—Check DEPENDENT OTHER when a dependent child's last name differs from the subscriber's last name
    - **BLOCK 15**—List the illness or injuries for which the patient received the service(s) listed on the itemized bill, receipt or explanation of benefits
    - **BLOCK 19**—When applicable indicate the following information obtained from the itemized bill or the doctor's office:
        - Length of time for anesthesia, intensive care or psychotherapy sessions
        - Length, location and number of lacerations
        - Location and number of lesions

- **QUESTIONS OR PROBLEMS**

- If you have any questions regarding the completion of this form, or require additional Subscriber Claim Forms, please contact Member Services at the address listed or call the Member Service Number listed on the back of your Identification Card.

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