Health Claim Form

MERITAIN® HEALTH
An Aetna Company

Complete and send to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057

IMPORTANT: Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill. A diagnosis must be shown on bill. Do not submit this form if injury occurred on the job. Please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding a work related claim.

Section 1. EMPLOYEE INFORMATION

Name (last, first, initial)			Sex	Employer Name	
Home Address			Identification Number	Birthdate	Group Number
City	State	Zip Code	Work Telephone ( )	Home Telephone ( )	

Section 2. PATIENT INFORMATION

The patient is: ☐ **The employee** (Go to section 3) ☐ **Employee's Spouse** (Complete spouse information) ☐ **Employee's Child** (Complete spouse and child information)

Spouse's Name (last, first, initial)	Sex	Child's Name (first, last, initial)	Sex
Spouse's Birthdate	Spouse's Social Security Number	Child's Birthdate	Child's Social Security Number
Spouse's Employer			
Spouse's Employer's Address			

Section 3. OTHER COVERAGE

☐ **Yes** (then complete) ☐ **No** (go to section 4) **Name of Policy Holder:**

Name of Other Health Insurance Carrier or Plan	Address	City	State	Zip Code
Other Insurance Carrier's or Plan's Telephone #	Type of Coverage ☐ **Group** ☐ **Individual**	Group Number	Contract or Policy Number	
Spouse's Employer				
Spouse's Employer's Address				

Section 4. ABOUT THIS CLAIM

☐ **Injury** ☐ **Illness**
Date and time of accident:

Describe injury, when and how it happened or nature of illness:
See attached

Was this injury the result of an accident? ☐ **Yes** ☐ **No**

If auto insurance was involved, please provide:	**Policy #**	**Name of insurance company**	**Address (city, state, zip)**

Was this a work-related injury? ☐ **Yes** ☒ **No**

If injury is work-related, please contact the Workers' Compensation Carrier/Administrator for proper instructions regarding this claim.

EMPLOYEE'S (or adult dependent's) SIGNATURE REQUIRED

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

Signature: **Date:**

ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)

I authorize payment of benefits to the doctor or supplier of services listed here.

Provider to be paid	Employee's Signature	
Provider's tax ID number or Social Security Number	NPI Number	Date