HAP CareSource™
a partner of hap

Member Claims Form

☐ **Dental Services**
☐ **All Other Services**

A. SUBSCRIBER INFORMATION

1a. Member ID:	2a. Health Plan:	3a. Phone Number: ( ) -	
4a. Last Name:	5a. First Name:	6a. MI:	7a. Date of Birth: / /
8a. Home Address:			
9a. City:	10a. State:	11a. ZIP:	

B. PATIENT INFORMATION

1b. Patient's Member ID:				
2b. Last Name:	3b. First Name:	4b. MI:	5b. Date of Birth: / /	
6b. Home Address:				
7b. City:	8b. State:	9b. ZIP:		
10b. Sex: ☐ ☐ M / F	11b. Relationship to Subscriber:	12b. Full Time Student: ☐ ☐ YES / NO	13b. School Name:	

C. ACCIDENT INFORMATION (if applicable)

1c. Accident Type: WORK / AUTO / OTHER ☐ ☐ ☐	2c. Date Accident Occurred: / /
3c. How did the accident occur?	

D. OTHER INSURANCE

1d. Is the patient covered by another insurance plan? ☐ YES / NO ☐ If yes, please complete the following:	
2d. Name of person carrying other insurance:	3d. Date of Birth: / /
4d. Member ID:	5d. Name of Other Insurance Carrier:
6d. Policy Number:	7d. Employer Name:

8d. **ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OF ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.**
I CERTIFY THAT THE INFORMATION SUPPLIED IS TRUE AND CORRECT.

Member or Parent/Guardian Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

1e. Please sign below *only if* you want HAP CareSource™ MI Coordinated Health (HMO D-SNP) to pay benefits directly to the provider of medical services.

Member or Parent/Guardian Signature: _____ Date: _____

Guidelines for Submitting Claims to HAP CareSource MI Coordinated Health

- Clip, do not staple, all bills to the completed form and mail them to HAP CareSource MI Coordinated Health at the address listed below.
- Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.
- Provide a copy of either a UB92 or HCFA1500 form (this form can be obtained from your provider of service.)
- Please include your Member # on all documents, and submit all claims to HAP CareSource in a timely manner.
- Submit claims to: **HAP CareSource MI Coordinated Health**
  ATTN: Claims
  P.O. Box 1186
  Dayton, OH 45401
- This form may not be used for pharmacy claims.