

- Dental services  
 All other services

## Member Claim Form



### A. SUBSCRIBER INFORMATION

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

### 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 Code:	
10b. Sex: M <input type="checkbox"/> F <input type="checkbox"/>	11b. Relationship to Subscriber:	12b. Full Time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	13b. School Name:

### C. ACCIDENT INFORMATION (if applicable)

1c. Accident Work <input type="checkbox"/> Auto <input type="checkbox"/> Other <input type="checkbox"/>	2c. Date Accident Occurred:    /    /
3c. How did the accident occur?	

### D. OTHER INSURANCE

1d. Is the patient covered by another insurance plan? Yes <input type="checkbox"/> No <input type="checkbox"/> 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:
<b>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.</b>	
Member or Parent/Guardian Signature: _____ Date: _____	

### E. ASSIGNMENT OF BENEFITS

1e. Please sign below <i>only if you want CareSource to pay benefits directly to the provider of medical services.</i>
Member or Parent/Guardian Signature: _____ Date: _____

### GUIDELINES FOR SUBMITTING CLAIMS TO CareSource

- Clip, do not staple, all bills to the completed form and mail them to **CareSource** 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 CareSource in a timely manner.
- Submit claims to: **PO Box 3607, Dayton, OH 45401-3607**
- This form may not be used for pharmacy claims