

- Dental services
 All other services

Member Claim Form



Health Care with Heart

CareSource Medicare Advantage plans

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:
<p>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.</p>		
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</i> of medical services.	
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: **CareSource PO Box 824, Dayton, OH 45401-0824**
- This form may not be used for pharmacy claims