☐ Dental services
☐ All other services

Member Claim Form

HAP CareSource™

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 ☐ F ☐	11b. Relationship to Subscriber:	12b. Full Time Student: Yes ☐ No ☐	13b. School Name:	

C. ACCIDENT INFORMATION (if applicable)

1c. Accident 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 to pay benefits directly to the provider* of medical services.

Member or Parent/Guardian Signature: _____ Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO HAP CareSource

- Clip, do not staple, all bills to the completed form and mail them to HAP **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 HAP CareSource in a timely manner.
- Submit claims to: <**P.O. Box 1186, Dayton, OH 45401-1186>**
- This form may not be used for pharmacy claims