



## 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

<sup>1d.</sup> Is the patient covered by another insurance plan? YES / NO	
If yes, please complete the following:	
<sup>2d.</sup> Name of person carrying other insurance:	<sup>3d.</sup> Date of Birth: / /
<sup>4d.</sup> Member ID:	<sup>5d.</sup> Name of Other Insurance Carrier:
<sup>6d.</sup> Policy Number:	<sup>7d.</sup> Employer Name:
<sup>8d.</sup> <b>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.</b> <b>I CERTIFY THAT THE INFORMATION SUPPLIED IS TRUE AND CORRECT.</b>	
Member or Parent/Guardian Signature: _____ Date: _____	

## E. ASSIGNMENT OF BENEFITS

<sup>1e.</sup> 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

<ul style="list-style-type: none"><li>• Clip, do not staple, all bills to the completed form and mail them to CareSource at the address listed below.</li><li>• Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.</li><li>• Provide a copy of either a UB92 or HCFA1500 form (this form can be obtained from your provider of service.)</li><li>• Please include your Member # on all documents, and submit all claims to CareSource in a timely manner.</li><li>• Submit claims to: <b>CareSource</b> <b>ATTN: Claims</b> <b>P.O. Box 36</b> <b>Dayton, OH 45420</b></li><li>• This form may not be used for pharmacy claims.</li></ul>
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