☐ **Dental services**
☐ **All other services**

Member Claim Form

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 CareSource to pay benefits directly to the provider* 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: **P.O. Box 8730, Dayton, OH 45401-8730**
- This form may not be used for pharmacy claims

ENGLISH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

SPANISH

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-488-0134 (TTY: 1-800-750-0750 or 711）。

GERMAN

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-488-0134 (رقم هاتف الصم والبكم: 711 أو 1-800-750-0750)

PENNSYLVANIA DUTCH

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-488-0134 (телетайп: 1-800-750-0750 or 711).

FRENCH

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-488-0134 (ATS :1-800-750-0750 or 711).

VIETNAMESE

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

CUSHITE/OROMO

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-488-0134 (TTY: 1-800-750-0750 or 711). 번으로 전화해 주십시오.

ITALIAN

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-488-0134 (TTY:1-800-750-0750 or 711）まで、お電話にてご連絡ください。

DUTCH

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

UKRAINIAN

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-488-0134 (телетайп: 1-800-750-0750 or 711).

ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

NEPALI

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-800-488-0134 (1-800-750-0750 टटिविाइ:711)।

SOMALI

DIGTOONI: Haddii aad ku hadasho Af Soomaali, adeegyada caawimada luqada, oo lacag la'aan ah, ayaa laguu heli karaa adiga. Wac 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

CareSource®

Notice of Non-Discrimination

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please call 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-800-488-0134 (TTY: 1-800-750-0750 or 711)
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CareSource®