HOW TO FILE A CLAIM

A. Network Providers

When you obtain care from a participating network provider, no claim forms are necessary and payment will be made directly to the provider.

B. All Other Providers*

1. Hospital Admission or Outpatient Surgery

   If it becomes necessary for you or one of your dependents to be admitted to a non-network hospital, the hospital will submit the claim form directly to PHCS and payment will be made directly to the provider. Please refer to your ID card for any precertification authorization requirements for hospital confinements.

2. Medical Expenses

   If it becomes necessary for you or one of your dependents to obtain care from a non-Network provider, it may be necessary to complete this Claim Form. Check with your provider to determine whether he or she will submit the claim form for you or whether you will be required to submit the claim form yourself. Please use a separate claim form for each family member.

   If you elect to have payment made directly to the provider, you **must** sign boxes 12 and 13 on the claim form and provide either a completed claim form or an original itemized bill that contains the following:

   A. The date(s) of service
   B. The procedure code(s) or a description of each
   C. The diagnosis code or a description

   If you have paid for services yourself and wish to be reimbursed, do **not** sign box 13 on the claim form, but do provide us with either a completed claim form or an itemized bill that contains the following:

   A. The date(s) of service
   B. The procedure code(s) or a description of each
   C. The diagnosis code or a description
   D. Proof of payment (canceled check front and back, credit card receipt or stamped receipt from the provider's office showing payment in full).

*May be paid under a regional network fee schedule

Claim forms are available from your employer's Plan Administrator or by calling a Tufts Health Plan Member Services coordinator at 800-423-8080.

WHERE TO FORWARD CLAIMS

Multiplan/PHCS Network
P.O. Box 5397
De Pere, WI 54115-5397

800-533-0090

Administered by Tufts Benefit Administrators, Inc.

TUFTS Health Plan

PHCS PRIVATE HEALTHCARE SYSTEMS

Multiplan/PHCS Network
P.O. Box 5397
De Pere, WI 54115-5397

CLAIM FORM

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S DATE OF BIRTH (MONTH, DAY, YEAR) SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER ☐ EMPLOYED ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT

CITY STATE

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH (MONTH, DAY, YEAR) SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH (MONTH, DAY, YEAR) SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (STATE)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO **If yes,** return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim.

SIGNED_____ Date_____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED_____

14. DATE OF CURRENT: (MONTH, DAY, YEAR) ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MONTH, DAY, YEAR)

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MONTH, DAY, YEAR) FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. ID NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MONTH, DAY, YEAR) FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE from MM DD YY	to MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX ID NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. TOTAL CHARGE $

28. AMOUNT PAID $

29. BALANCE DUE $

30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

31. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)

32. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GROUP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION