



**INSTRUCTIONS FOR FILING A CLAIM**

A separate claim is required for each patient for whom a claim is made. Members should **NOT** pay PPO Network Providers.

**This form cannot be emailed - complete all items before printing!**

- A. Please be sure that all information requested on the claim form is fully completed. Claims that are incomplete will be delayed and may have to be returned unprocessed.
- B. If you wish payment to be made directly to the physician or supplier of service, complete the appropriate "assignment", item 13. If there is not sufficient room, write on the bill "Pay Provider Directly", date and sign your name. Assignments without signature may not be valid.
- C. All itemized bills must include the following: 1-Name of patient 2-Date of service 3-Type and CPT code for each service 4-Nature of illness or injury (diagnosis) 5- amount.
- D. Mail to INDECS at the above PO Box address, or fax to claim services.

**Note: Receipts, balance due statements, EOB statements from other carriers or cancelled checks are not acceptable as itemized bills.**

<b>TO BE COMPLETED BY MEMBER</b>		<b>IMPORTANT NOTICE: ITEMS 1-13 MUST BE COMPLETED IN FULL FOR EACH CLAIM. PRINT FORM, THEN SIGN ITEM 12 AND ITEM 13 IF YOU WANT BENEFITS PAID TO PROVIDER(S).</b>	
1	a) Name of Employee/Plan Member _____	b) SSN _____	
2	a) This Claim is for: (First, MI, Last, Name if Different): _____	b) Claimant's Sex <input type="checkbox"/> M <input type="checkbox"/> F	c) DOB _____
3	a) Name of Member's Employer _____	<b>MEMBER'S STATUS</b>	
	a) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	c) Birth Date _____	d) <input type="checkbox"/> M <input type="checkbox"/> F e) <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA
4	a) Member's Home Address: Street _____ City _____ State _____ Zip Code _____	b) Is this a new address? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5	a) Claim is for: <input type="checkbox"/> Member/Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	If Other, Explain: _____	b) Claimant's Employer: _____
6	a) Is Claimant eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Effective Date: Mo. _____ Yr. _____	b) Is Claimant handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No	c) Is Claimant full-time student over age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No
7	a) If Student is over age 19, name of school presently attending: _____	Street _____ City _____ State _____ Zip Code _____	
8	a) Is the Member, Spouse or Dependent Child entitled to Benefits from any other kind of Group Health Insurance or Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>IF YES:</b> name and birthday of person with other coverage: NAME _____ DOB _____ And Complete 8b-g regarding other coverage.	b) Is the Person in 8a employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give Employer's full name & address: _____	
		c) Name & Address of other Insurance Company or Organization where claims are submitted: _____	d) Effective Date _____
		e) Relationship to Member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	f) Group Policy/Contract # _____
9	a) Diagnosis or Nature of Illness or Injury for which claim is made: _____	b) Date first treated for this Condition: _____	c) Is this Condition due to an Occupational Injury or Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
10	a) Is claim based on an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	b) Did accident happen while working? <input type="checkbox"/> Yes <input type="checkbox"/> No	c) Auto Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
		d) Other <input type="checkbox"/> Yes <input type="checkbox"/> No	e) Date/Time of Accident _____
11	IF Yes in Section 10, how and where did accident happen: _____		
12	<b>Must be signed here</b> AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize INDECS Corp. to release or obtain any information which may be necessary to determine benefits payable under the Group Plan. A photocopy of this authorization shall be valid. I certify to the truth of the answers on this form, knowing that false or fraudulent information is punishable under the law. Member's Signature: _____ Claimant (if adult): _____ Date: _____		

<b>13 SIGN FOR BENEFITS TO BE PAID TO PROVIDER</b>	ASSIGNMENT: I authorize and request that payment be made directly to the following provider(s). <b>I understand that I am financially responsible for charges not paid by this assignment: (see filing instruction B, if more than 3 assignments.)</b> <input type="checkbox"/> <b>YES;</b> TO: 1. _____ 2. _____ or <input type="checkbox"/> <b>NO, DO NOT PAY PROVIDER(S)</b> (Note: PPO Network Providers <u>MUST</u> be paid by Plan.) 3. _____ Member's Signature: _____ Date _____
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**ARE ITEMIZED BILLS\* ENCLOSED?**

\*An itemized bill is one that shows the patient's name, relationship, date of service, the type, and CPT code for each service rendered, the nature of the condition (diagnosis) being treated, amount of charge for each service or supply (must be itemized) and provider's tax identification number.

**FOR CLAIMS OR COVERAGE INFORMATION CALL: 1-888-4INDECS (446-3327)**