

Instructions for Filing a Claim			
<p>A. COMPLETE EMPLOYEE'S STATEMENT. Please be sure to answer every question.</p> <p>B. Complete "Authorization to Release Information" for hospital, physician's or dentist's statement.</p> <p>C. All bills must show patient's name, date(s) of treatment, nature of treatment (diagnosis), fee for each service and the tax identification number of the provider. The hospital, doctor or other provider may forward claims directly to the address shown below or to the employee.</p> <p>D. If you wish payment made directly to the hospital or doctor, complete the appropriate "Authorization to Pay Benefits".</p> <p>E. MAIL COMPLETED FORM TO: HealthNow Administrative Services, P.O. Box 211034, Eagan, MN 55121. Phone: 1-855-581-1809.</p> <p>When submitting an itemized bill, please retain a copy for your records.</p>			
Employee's Statement of Claim for Group Health Benefits			
I HEREBY PRESENT THIS CLAIM, and authorize any individual or organization to release information required for its acceptance.			
1 CLAIM IS BEING MADE FOR: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child			
2 Patient's Name		Date of Birth	Sex
3 Is claim due to auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date and place of accident or injury	
Describe accident: (Indicate name of state where accident occurred or provide brief description of incident)			
4 Is this claim the result of a work related illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5 Are you (employee) married? <input type="checkbox"/> Yes <input type="checkbox"/> No Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		5a If claim is for a dependent child, is the child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Spouse _____ Employer _____ Address _____		Employer _____ Address _____	
6 If patient is spouse or dependent, are they also covered by any of the following: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check box below which applies and complete 6a. <input type="checkbox"/> Group health benefits of any kind. <input type="checkbox"/> Coverage of medical care expenses provided by an employer or union welfare plan, any federal state provincial or other government program. <input type="checkbox"/> Other arrangement of benefits, for individuals of a group		6a Give name, address and telephone number of other company or organization providing benefits Name _____ Address _____	
7 Employee's Name (Please Print)		Employee's Signature	Social Security Number
Address _____ City _____ State _____ Zip Code _____		Date _____	
8 Employee's Birthdate		Spouse's Birthdate	

PATIENT AUTHORIZATION

AUTHORIZATION FOR USE IN CLAIMING GROUP BENEFITS

To all physicians and other medical professionals, hospitals and other medical-care institutions and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators.

You are authorized to provide HealthNow Administrative Services and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on HealthNow Administrative Services' behalf, with information concerning medical care, advice, treatment or supplies provided the patient and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administering claims for benefits.

I understand that the duration of the authorization is for the term of coverage of the plan under which a claim for health benefits has been submitted.

I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

DATE: _____ PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: _____

RELATIONSHIP OF AUTHORIZED PERSON: _____

AUTHORIZATION TO PAY HOSPITAL/PHYSICIAN

I hereby authorize payment directly to the below named hospital and/or physician otherwise payable to me for services described below. I understand I am financially responsible for the hospital medical and/or physician charges not covered by this authorization.

DATE: _____ EMPLOYEE SIGNATURE: _____