

Texas PPO Medical Claim Form

INSTRUCTIONS FOR SUBMITTING CLAIMS

1. Use a separate form for each family member, each different provider of service, and each itemized bill.
2. Attach a fully itemized bill or ask the provider to complete the other side of this form.
FULLY ITEMIZED BILLS MUST CONTAIN THE FOLLOWING INFORMATION: Date of service, diagnosis, type of service, procedure number, charge for each service, provider name, address, phone number, provider tax ID number.
3. A signature line for AUTHORIZATION TO PAY PROVIDER is given below. This directs PacifiCare to pay the provider. If you choose not to sign this authorization, benefits will be paid to you.
4. Please send claims to PacifiCare: P.O. Box 6099 • Cypress, CA 90630
5. If you have questions regarding your claim or need additional claim forms or claim record envelopes, please call: 1-866-316-9776.
6. Reimbursement of pharmacy expense is outlined in your member materials. (Do not use this form for pharmacy claims.)

EMPLOYEE INFORMATION (Complete For All Claims)

| | | | | |
|---|----------------|---------------------------|-------|----------|
| EMPLOYER NAME | | GROUP NUMBER | | |
| EMPLOYEE'S NAME (LAST, FIRST M.I.) | | EMPLOYEE'S STREET ADDRESS | | |
| EMPLOYEE'S DATE OF BIRTH | EMPLOYEE'S SSN | CITY | STATE | ZIP CODE |
| THIS CLAIM IS FOR: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER - PLEASE SPECIFY | | | | |

PATIENT INFORMATION

| | | | | |
|---|--|--|-------------------------------|---------------|
| PATIENT'S NAME (LAST, FIRST M.I.) | | PATIENT'S DATE OF BIRTH | PACIFICARE ID# | |
| PATIENT IS (Check if applicable) <input type="checkbox"/> FEMALE <input type="checkbox"/> MARRIED <input type="checkbox"/> DISABLED <input type="checkbox"/> RETIRED | | If patient is disabled, give date of disability | | |
| <input type="checkbox"/> MALE <input type="checkbox"/> SINGLE <input type="checkbox"/> ON MEDICARE <input type="checkbox"/> STUDENT | | | | |
| Patient was treated for: <input type="checkbox"/> ILLNESS <input type="checkbox"/> PREGNANCY <input type="checkbox"/> INJURY AT WORK <input type="checkbox"/> ACCIDENTAL INJURY <input type="checkbox"/> OTHER - PLEASE SPECIFY | | | | |
| If accident involved, give date, how and where accident occurred | | | | |
| Does patient have other health coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO | | IF YES, NAME OF INSURANCE COMPANY | GROUP NUMBER | POLICY NUMBER |
| ADDRESS OF INSURANCE COMPANY | | | | |
| NAME OF POLICY HOLDER | | SEX OF POLICY HOLDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE | POLICY HOLDER'S DATE OF BIRTH | |
| NAME OF POLICY HOLDER'S EMPLOYER | | POLICY HOLDER'S EMPLOYER'S ADDRESS | | |

AUTHORIZATIONS

| | |
|--|---|
| <p>RELEASE OF INFORMATION I hereby authorize the release of any medical information necessary to process this claim.</p> <p>_____ PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE DATE</p> | <p>AUTHORIZATION TO PAY BENEFITS TO PROVIDER I hereby authorize benefits to be paid directly to the provider of service for this claim.</p> <p>_____ PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE DATE</p> |
|--|---|

PLEASE ATTACH AN ITEMIZED BILL OR ASK THE PROVIDER OF SERVICE TO FILL OUT THE OTHER SIDE OF THIS CLAIM FORM

PHYSICIAN OR SUPPLIER INFORMATION

| | | | | |
|--|---|--|--|---|
| Date of illness (first symptom) OR injury (accident) OR pregnancy (LMP) | | Date you were first consulted for this condition | If patient has had same or similar injury, give dates | If emergency, check here <input type="checkbox"/> |
| Date patient able to return to work | Dates of total disability FROM _____ THROUGH _____ | | Dates of partial disability FROM _____ THROUGH _____ | |
| Name of referring physician or other source (e.g., Public Health Agency) | | | For services related to hospitalization, give dates ADMITTED _____ DISCHARGED _____ | |
| Name and address of facility where services were rendered (if other than home or office) | | | Was laboratory work performed outside your office? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | |
|---|--|
| Diagnosis or nature of illness or injury 1 _____ 2 _____ 3 _____ 4 _____ Please relate diagnosis to procedures using reference numbers (1,2,3, etc.) | FAMILY PLANNING <input type="checkbox"/> Yes <input type="checkbox"/> No Prior Authorization # <input type="text"/> |
|---|--|

| Date of Service | Place of Service | Procedure Code | Fully describe procedures, medical services, or supplies for each date (explain unusual services or circumstances) | Diagnosis Code | Charges | Days or units | TDS | For PacifiCare use only |
|-----------------|------------------|----------------|--|----------------|---------|---------------|-----|-------------------------|
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|---------------------|--------------|----------|-------------|
| Patient's Account # | Total Charge | Amt Paid | Balance Due |
|---------------------|--------------|----------|-------------|

| | |
|--------------------|---------------------|
| Provider's Name | Provider's Address |
| Provider's Phone # | Provider's Tax ID # |

| | | | |
|-----------------------------|------------------------------|-----------------------------------|---------------------------------|
| 21 (IH) INPATIENT HOSPITAL | 12 (H) PATIENT'S HOME | 32 (NH) NURSING HOME | 99 (OL) OTHER LOCATIONS |
| 22 (OH) OUTPATIENT HOSPITAL | 52 (PSY) DAY CARE FACILITY | 31 (SNF) SKILLED NURSING FACILITY | 81 (IL) INDEPENDENT LABORATORY |
| 11 (O) DOCTOR'S OFFICE | 52 (PSY) NIGHT CARE FACILITY | 41 (AMB) AMBULANCE | 99 (OMF) OTHER MEDICAL FACILITY |

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED AND PAYMENT IS THEREFORE DUE.

Signature of Provider (including degree or credentials) _____ Date _____

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM FORM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE FOUND GUILTY OF INSURANCE FRAUD.

MAIL COMPLETED CLAIM FORM TO:

PacifiCare[®]
Life Assurance Company

P.O. Box 6099
Cypress, CA 90630