

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

PHCS, Inc.
P.O. Box 2474
Des Plaines, IL 60017-2474

800-533-0090

Administered by Tufts Benefit Administrators, Inc.

CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					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 <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)							
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			7. INSURED'S ADDRESS (No., Street)							
CITY STATE			8. PATIENT STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> OTHER			CITY STATE			TELEPHONE (INCLUDE AREA CODE)				
ZIP CODE TELEPHONE (INCLUDE AREA CODE)			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			11. INSURED'S POLICY GROUP OR FECA NUMBER							
a. OTHER INSURED'S POLICY OR GROUP NUMBER			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH (MONTH, DAY, YEAR) SEX M <input type="checkbox"/> F <input type="checkbox"/>							
b. OTHER INSURED'S DATE OF BIRTH (MONTH, DAY, YEAR) SEX M <input type="checkbox"/> F <input type="checkbox"/>			b. AUTO ACCIDENT? PLACE (STATE) <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME							
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim.										SIGNED _____			
SIGNED _____ Date _____										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				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			
19. RESERVED FOR LOCAL USE										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE										23. PRIOR AUTHORIZATION NUMBER			
1. _____ 3. _____													
2. _____ 4. _____													
24. A		B	C	D			E	F	G	H	I	J	K
DATE(S) OF SERVICE from to		Place of Service	Type of Service	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM DD YY MM DD YY													
1													
2													
3													
4													
5													
6													
25. FEDERAL TAX ID NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			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.)			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 #							
SIGNED _____ DATE _____						PIN#		GROUP#					

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION