Medical Claim Form

Save this PDF to your computer prior to filling out the form. Use your provider's itemized bills to complete the medical claim form. **Separate claim forms must be submitted for each different provider and copies of receipts must be included**. Your cooperation in **FULLY** completing this form and providing necessary documentation will help ensure quick and accurate processing. Follow the step-by-step instruction sheet (page 3) included with this form. **Please be sure to type or print legibly.**

Section 1: Subscriber/Insured's Information

Last Name	**First Name**	**M.I.**
ID Number (Found on Medical Mutual of Ohio ID Card)	**Date of Birth** _____/_____/_____	**Sex** ☐ Male ☐ Female

Section 2: Patient Information (*If different from subscriber*)

Last Name	**First Name**	**M.I.**
Date of Birth _____/_____/_____	**Relationship to Subscriber**	**Sex** ☐ Male ☐ Female

Section 3: Coordination of Benefits – Other Insurance

Does the patient have other health insurance coverage: ☐ Yes ☐ No **If other insurance is your primary carrier, please include a copy of your EOB (Explanation of Benefits)**	
Subscriber / Insured's Name:	
Name of other insurance company:	
Group #	**Policy #**

Section 4: Place of service (POS 2-digit #) and other related information

Place of Service Code: _____ **Please call your provider for the 2-digit (POS) Place of Service code.**

Where was this service rendered? ☐ Physician office ☐ Medical Equipment Supplier ☐ Hospital

☐ Ambulance ☐ Pharmacy ☐ Laboratory ☐ Telehealth ☐ Other_____

Was this medical expense the result of an auto accident? ☐ Yes ☐ No Other accident? ☐ Yes ☐ No

Was this job related? ☐ Yes ☐ No If yes to any, please list date of occurrence: _____/ _____/_____

On this page, please list the following information: Dates of service, procedure codes, diagnosis codes and charges for each service provided. **Please attach a copy of your receipt showing payment for all charges you list below.** Refer to the instruction sheet on the next page for further details if needed.

Date of Service	Procedure Codes	Diagnosis Codes	Charges
Example: 01/01/9999	99199	R99	0.00

Section 6: Provider Information (Claim cannot be processed without the following information)

Provider's Federal Tax ID # (9-digits):
Treating Provider's Service NPI # (10-digits):
Provider's Billing NPI # (10-digits):
Treating Provider's Name:
Provider's Service Address (No P.O. Boxes):
Provider's Billing Address:

Instruction sheet:

Section 1: All subscriber/insured's information should be listed in this section.

Section 2: All patient information should be listed in this section.

Section 3: If the patient has more than one health insurance policy, please list all information for that additional plan in this section. Be sure to include a copy of your EOB if your other carrier is primary.

Section 4: Place of service (2-digit code) and accident information if applicable. If unknown, your provider should be able to give you this information.

Section 5: All dates of service, procedure codes (5-digit code), and diagnosis codes (alpha/numeric) related to each individual charge.

Section 6: All provider information, including providers name, Tax ID # (9-digits), NPI # (10-digits) and complete address. **(Without this information the claim cannot be processed.)**

Please be sure to contact your provider directly if you have any questions about the information requested on this form. For additional assistance, you may also contact Medical Mutual Customer Care at 1-800-382-5729.

Reminder: A separate claim form must be submitted for each individual provider to be processed properly, and a copy of your receipt **must** be included. **Please be sure to print all information clearly.**