Medical Claim Form

Mail: Core Management Resources
P.O. Box 90
Macon, GA 31202
Fax: 478-750-1705

This form can be used for all medical plans.

This form needs to be completed only if the provider is not submitting the claim on your behalf.

Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.

Please print clearly

PATIENT INFORMATION			MEMBER INFORMATION		
NAME Last	First	MI	MEMBER ID NUMBER or SOCIAL SECURITY NUMBER		
DATE OF BIRTH	SEX ❑ M ❑ F	RELATION TO MEMBER ❑ Self ❑ Spouse ❑ Child	NAME Last	First	MI
DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? ❑ Yes ❑ No			ADDRESS		
NAME/ADDRESS OF OTHER HEALTH INSURANCE COMPANY			CITY	STATE	ZIP CODE
GROUP/POLICY NUMBER			DAYTIME TELEPHONE # ( )	DATE OF BIRTH	

CLAIM INFORMATION

ACCIDENT OR ILLNESS DUE TO EMPLOYMENT? ❑ Yes ❑ No	INJURY DUE TO AUTO ACCIDENT? ❑ Yes ❑ No	BRIEFLY DESCRIBE ILLNESS/INJURY
DATE OF ACCIDENT	PLACE OF ACCIDENT	HAVE YOU FILED FOR WORKERS COMPENSATION? ❑ Yes ❑ No ❑ N/A

DATE OF SERVICE (Mo/Day/Year)	PROVIDER OF SERVICE (Name of Doctor, Lab, etc.)	SERVICE RENDERED (Office Visit, X-ray, etc.)	ILLNESS OR DIAGNOSIS	CHARGES

PROOF OF PAYMENT

Provider will be paid unless receipt of payment is attached with claim form.

All hospital submissions must be itemized on a UB92 Form with proof of payment (Box 54) completed.
All physician submissions must be itemized on a HCFA/CMS 1500 Form with proof of payment (Box 29) completed.

TOTAL

$

PAYMENT INSTRUCTIONS (If signed, payment will be made directly to provider)

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s).

MEMBER'S SIGNATURE **DATE**

X

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Member, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

MEMBER'S SIGNATURE **DATE**

X

Dental Claim Form

Mail: Core Management Resources
P.O. Box 90
Macon, GA 31202
Fax: 478-750-1705

This form can be used for all dental plans.

This form needs to be completed only if the provider is not submitting the claim on your behalf.

Out-of-network claims can be submitted by the provider if the provider is able and willing to file on your behalf.

Please print clearly

PATIENT INFORMATION

NAME Last First MI

DATE OF BIRTH

SEX ❑ M ❑ F

RELATION TO MEMBER ❑ Self ❑ Spouse ❑ Child

DOES THE PATIENT HAVE OTHER DENTAL INSURANCE COVERAGE?
❑ Yes ❑ No

NAME/ADDRESS OF OTHER DENTAL INSURANCE COMPANY

GROUP/POLICY NUMBER

MEMBER INFORMATION

MEMBER ID NUMBER or SOCIAL SECURITY NUMBER

NAME Last First MI

ADDRESS

CITY STATE ZIP CODE

DAYTIME TELEPHONE # ( )

DATE OF BIRTH

CLAIM INFORMATION

ACCIDENT OR ILLNESS DUE TO EMPLOYMENT?
❑ Yes ❑ No

INJURY DUE TO AUTO ACCIDENT?
❑ Yes ❑ No

IF YES, BRIEFLY DECRIBE ILLNESS/INJURY (GIVE DATE AND PLACE):

IS TREATMENT FOR ORTHODONTICS? ❑ Yes ❑ No

DATE APPLIANCE PLACED

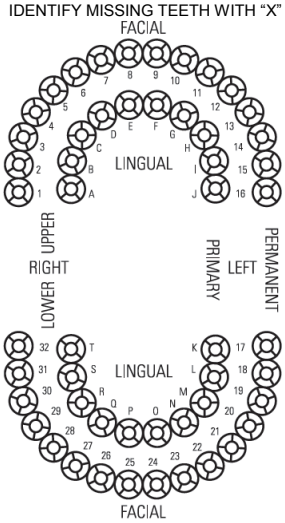
MONTHS OF TREATMENT REMAINING:

IF PROTHESIS, IS THIS INTIAL PLACEMENT? ❑ Yes ❑ No

IF NO, REASON FOR REPLACEMENT:

DATE OF PRIOR PLACEMENT

IDENTIFY MISSING TEETH WITH "X"



REMARKS:

PROCEDURE DATE	TOOTH # OR LETTER	TOOTH SURFACE	DESCRIPTION OF SERVICE	PROCEDURE CODE	CHARGES

PROOF OF PAYMENT

Provider will be paid unless receipt of payment is attached with claim form.

TOTAL $

PAYMENT INSTRUCTIONS (If signed, payment will be made directly to provider)

I authorize payment to be made directly to the healthcare provider(s) indicated on the enclosed bill(s).

MEMBER'S SIGNATURE **DATE**

X

AUTHORIZATION

I certify that the information I have given is accurate to the best of my knowledge and that I, as the Member, am claiming benefits only for the charges incurred by the patient identified above. I authorize the release of any medical information necessary to process this claim.

MEMBER'S SIGNATURE **DATE**

X