YOUR INSURANCE COMPANY HERE:

Staple itemized statement or receipt here to the back of this form

Member Claim Submission Form

To be considered a valid claim, submit your receipt or itemized statement along with this completed claim form containing the required information. Please refer to item #6 on the back of this form for the items required for claim submission. **If sufficient documentation is not received, claim will not be processed.**

Name of Employer: _____ Plan Group Number: _____

Name of Employee: _____ Member ID: _____

Patient's Name: _____ Date of Birth: _____

Employee Phone Number and/or Email Address: _____

Issue Payment to: ■ Member ☐ Provider

Facility Name: SPINE AND MOVEMENT CENTER Provider Tax ID # 9 Digits: **(USA only)** 93-3379190

Provider Name: Caroline Humberston, PT, CSCS

Provider Address: 6904 Spring Valley Dr, Suite 307, Holland, OH 43528 **(required field - please contact your provider if statement is missing this information)**

Type of Service	Check all that apply. **PLEASE NOTE - ALL SERVICE TYPES MAY NOT BE COVERED UNDER YOUR PLAN.**				
☐ Vision	☐ Exam	☐ Frame	☐ Lenses	☐ Contacts	☐ Other (complete below)
■ Medical	■ Office Visit	☐ Flu Shot	☐ Breast Pump		
	☐ Lab	☐ Immunization	☐ Durable medical equipment		
	☐ X-Ray	☐ Prescription	☐ Other (complete below)		
☐ Foreign	☐ Office Visit	☐ Hospital	☐ Emergency		
	☐ Lab	☐ X-Ray	☐ Prescription		
	☐ Other: _____				
	Date of Service: _____		Country: _____		
	Charges in USD: $ _____		Diagnosis: _____		

If you checked Other, please complete the information below:

Please use this space to briefly describe services rendered
Example - UV Coating, Wellness/Gym Membership, Acupuncture, Foreign claims (ALL SERVICE TYPES MAY NOT BE COVERED UNDER YOUR PLAN.)

You may submit your claim to by one of the following methods:

FAX:

Mail:

Email a pdf of your claim and documents to:

See back of form for complete claim filing instructions

Filing your claim is easy. Please review these important tips.

1 Use this form to file a claim for any eligible medical expense when your physician or other provider does not file a claim. Please print clearly with black ink completing all required fields.

2 Attach your itemized statement (or fully legible copy of the bill) to the back of this form. Keep a copy for your records.

Please use a separate claim form for each health care professional and for each family member.

3 See your ID card for:
*Name of Employer
*Plan Group Number
*Name of Member (as it appear on the ID card)

4 Patient name and date of birth must match eligibility file.
Example - if your name was Eugene Smith on your enrollment form, claim must state Eugene, not Gene

5 Name, address and Tax ID number of the provider of service is required. If the provider's Tax ID number (9 digit number) is not on your copy of the receipt, you can contact their office to obtain it.

6 To be considered a valid claim, (with the exception of gym memberships) your bill should include the following information:
-Patient name
-Date of service
-Description of service (i.e.: office visit, injection, immunization, glasses)
-Diagnosis (type of illness or injury)
-A charge of each service
-Name, address and Tax ID number of the provider (required field for services rendered in the US or US territories)

7 If your plan covers gym memberships or other services not considered traditional medical expenses, the information needed to file a claim can vary. Date of service and diagnosis may not apply.

8 Balance Due Statements are not valid claims. See above for information needed to constitute a valid claim.

9 Your submission will be scanned. Staple any attachments to the back of the claim form, not the front. Additionally, please indicate the member number on any attachments, should paperwork be separated from the claim form.

10 Claim address listed on the bottom of the claim form is for member use only; providers should bill to the address on the member ID card. This fax number also supports international faxing.

11 Only Prescriptions/drug charges that are allowable under your medical plan should be submitted on this form

12 Foreign Claims: Please complete all the fields including type of service, Date of Service, Country, Charges in US dollars (Please provide a receipts of payment in us Dollars), and the Diagnosis code or Diagnosis Description. If translation is needed to complete the processing of your claim it may delay processing. Any information that is able to be provided in English will expedite processing.