

PATIENT'S REQUEST FOR MEDICAL PAYMENT

PLEASE TYPE OR PRINT INFORMATION

Beneficiary Name:

<input type="checkbox"/> Male	<input type="checkbox"/> Female	Member Number:	Phone:
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Current address:

City:	State:	ZIP Code:
<input type="checkbox"/> Check here if this is a new address		

Previous address:

City:	State:	ZIP Code:
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Describe the illness or injury for which the patient received treatment:

Condition related to Patient's employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Condition related to an Accident?	<input type="checkbox"/> Auto	<input type="checkbox"/> Other
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Was patient being treated with chronic dialysis or kidney transplant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Are you employed and covered under an employee health plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Is your spouse employed and are you covered under your spouse's employee health plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If you have medical coverage other than Optima, such as private insurance, employment related insurance, State Agency (Medicaid) or the VA complete:

Name and address of other insurance, State Agency (Medicaid) or VA office:

Policyholder's Name:

Policy or Medical Assistance Number:

I authorize any holder of Medical or Other Information about me to release to Optima Health any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to me.

IMPORTANT: ATTACH ITEMIZED BILL(S) FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM
SEND COMPLETED FORM TO: OPTIMA MEDICARE, CLAIMS DEPARTMENT
4417 Corporation Lane, Virginia Beach, VA 23462

Signature of Patient (If unable to sign, See instructions)	Date:
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HOW TO FILL OUT THIS FORM

Optima will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill has to be paid before you submit this claim for payment and you **MUST** attach an itemized bill in order for Optima to process this claim.

Mail your completed claim form to:

Optima Medicare, Claims Department, 4417 Corporation Lane, Virginia Beach, VA 23462.

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

1. Print your name shown on your Optima Medicare Card
2. Print your Optima Medicare Identification Number. Check the appropriate box for the patient's sex.
3. Furnish your mailing address and include your phone number.
4. Describe the illness or injury for which you received treatment.
5. Check the appropriate boxes.
6. Be sure to sign your name. If you cannot write your name, make an (X) mark. Then have a witness sign his/her name.
7. Print the date you completed the form.

B. Each itemized bill MUST show all of the following:

1. Date of each service
2. Place of each service
3. Description of each surgical or medical service or supply furnished
4. Charge for EACH service
5. Doctor's or Supplier's name and address.
6. It is helpful if the diagnosis is also shown on the physician's bill.

COLLECTION AND USE OF INFORMATION

The information we obtain to complete your claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Optima Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations as necessary to administer your benefits under the Optima Medicare program. For example, it may be necessary to disclose information to a hospital or doctor about the benefits you have used.

Failure to furnish information regarding medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or member ID number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment.