AmeriHealth
NEW JERSEY

Claim Form (see reverse side for instructions)

MEMBER/PATIENT

Member's Name (First, Middle, Last)	Identification No.	Group No.
Present Address-Street ☐ New Address	City, State	Zip Code
Patient's Name (First, Middle, Last)		
Relationship of Patient To Member ☐ Self ☐ Spouse ☐ Child ☐ Handicapped dependent ☐ Other	Sex	DOB ___ / ___ / ___

OTHER INSURANCE

Does the PATIENT have additional health insurance? ☐ No ☐ Yes If yes, complete Part II:

Policyholder's Name	DOB ___ / ___ / ___	Zip Code

Employment Status of Policyholder ☐ Active ☐ Disabled ☐ Retired ☐ Effective Date: ___ / ___ / ___

Relationship of Policyholder to Member ☐ Self ☐ Spouse ☐ Child ☐ Other

Other Insurance Carrier's Name	Identification No.	Effective Date: ___ / ___ / ___

Type(s) of Coverage ☐ Hospitalization ☐ Medical-Surgical ☐ Dental ☐ Vision ☐ Drug ☐ Major Medical ☐ Other (specify) _____

Contract Covers ☐ Policyholder Only ☐ Policyholder and Spouse ☐ Policyholder and Child(ren) ☐ Family

Is the PATIENT entitled to benefits under MEDICARE HOSPITALIZATION Insurance (Part A)?
☐ No ☐ Yes Effective Date ___ / ___ / ___   Medicare ID Number_____

Does the PATIENT receive benefits under MEDICARE MEDICAL Insurance (Part B)?
☐ No ☐ Yes Effective Date ___ / ___ / ___   Medicare ID Number_____

If you answered "yes" to either of the above, give employment status of the Member listed in Part "I": ☐ Active ☐ Retired ☐ Disabled

PATIENT'S CONDITION

Describe conditions for which you are requesting benefits at this time:

Type of Injury or Illness	Name of Doctor Treating Injury/Illness	Date of First Symptoms
A.		
B.		

Were Services Related To Hospitalization? ☐ No ☐ Yes If yes, please fill in boxes below:

Date of Admission ___ / ___ / ___	Date of Discharge ___ / ___ / ___
Hospital Name _____	Admitting Physician _____

Were Expenses Due To An Accident? ☐ No ☐ Yes If yes, give type/place of accident:

Date of accident 2 / 1 / 3 ☐ Work ☐ Auto ☐ Other (specify) _____

Is this claim for prescription drugs? ☐ No ☐ Yes If yes, please give: Pharmacy Name _____ Address _____

NDC Number (obtain from Pharmacist): _ _ _ _ _ - _ _ _ _ - _ _

AUTHORIZATION

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to AmeriHealth all medical or other information requested for the processing of this claim. I hereby agree to reimburse AmeriHealth in full should this claim be incorrectly paid. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Member Signature	Date 2 / 3 / 4	Home Phone	Work Phone

If your provider is participating in AmeriHealth, the provider will submit a claim for you. This claim form should only be submitted when you use a non-participating AmeriHealth provider who does not submit a claim for you.

1. Please attach itemized bills to this claim form. These bills should include the following information:
   - **Name, address, and telephone number** (on official bill head) of the **provider** rendering the service or supplying the item.
   - **Patient's full name**
   - **Description of each service** rendered or item supplied
   - **Date and amount charged** for each service rendered or item supplied
   - **Diagnosis** of ailment

2. Please be sure that a **physician's medical certification** accompanies bills for:
   - Purchase or rental of medical equipment

3. When you are submitting expenses for more than one family member, please use a SEPARATE claim form for each person.

4. Please complete the claim form carefully, and be sure to include the information requested above. This will help to avoid unnecessary delays in processing your claim.

5. Prescription drug purchases made at network pharmacies do not require you to submit a claim form. The pharmacist will file the claim for you, and any resulting benefit payments will be made directly to you. If you purchase your prescription drug at a non-network pharmacy, you may still be entitled to reimbursement for a portion of your prescription drug expenses by completing Section III of this claim form. Be sure to include itemized receipts for each prescription. Remember to ask your pharmacist for the NDC number of the drug you purchase, and record that number in Section III on the front of this form.

AmeriHealth
N E W   J E R S E Y

Language Taglines and Nondiscrimination Notice

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥត គិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

(OVER)

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:
- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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