☐ Dental services
☐ All other services

# Member Claim Form

## A. SUBSCRIBER INFORMATION

| 1a. Member ID | 2a. Health Plan | 3a. Phone #: ( ) | |
|---|---|---|---|
| 4a. Last Name: | 5a. First Name: | 6a. MI: | 7a. Date of Birth / / |
| 8a. Home Address: | | | |
| 9a. City: | 10a. State: | 11a. Zip Code: | |

## B. PATIENT INFORMATION

| 1b. Patient's Member ID: | | | |
|---|---|---|---|
| 2b. Last Name: | 3b. First Name: | 4b. MI: | 5b. Date of Birth / / |
| 6b. Home Address: | | | |
| 7b. City: | 8b. State: | 9b. Zip Code: | |
| 10b. Sex: M ☐ F ☐ | 11b. Relationship to Subscriber: | 12b. Full Time Student: Yes ☐ No ☐ | 13b. School Name: |

## C. ACCIDENT INFORMATION (if applicable)

| 1c. Accident Work ☐ Auto ☐ Other ☐ | 2c. Date Accident Occurred: / / |
|---|---|
| 3c. How did the accident occur? | |

## D. OTHER INSURANCE

| 1d. Is the patient covered by another insurance plan? Yes ☐ No ☐ If yes, please complete the following: | |
|---|---|
| 2d. Name of person carrying other insurance: | 3d. Date of Birth / / |
| 4d. Member ID: | 5d. Name of Other Insurance Carrier: |
| 6d. Policy Number: | 7d. Employer Name: |

8d. **ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OF ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES. I CERTIFY THAT THE INFORMATION SUPPLIED IS TRUE AND CORRECT.**

Member or Parent/Guardian Signature: ______________________________ Date: ____________

## E. ASSIGNMENT OF BENEFITS

1e. Please sign below *only if you want Common Ground Healthcare Cooperative (CGHC) to pay benefits directly to the provider* of medical services. If payment is sent to the subscriber, the subscriber is responsible for paying the provider.

Member or Parent/Guardian Signature: ______________________________ Date: ____________

## GUIDELINES FOR SUBMITTING CLAIMS TO CGHC

- Clip (do not staple) all bills to the completed form and mail them to **CGHC** at the address listed below
- **Make sure all bills indicate a diagnosis code, procedure code, date of service and cost**
- **Provide a copy of either a UB92 or HCFA1500 form (this form can be obtained from your provider of service)**
- Please include your **Member #** on all documents, and submit all claims to CGHC in a timely manner
- Submit claims to: **Common Ground Healthcare Cooperative, P.O. BOX 1305, Dayton, OH 45401-1305**
- This form may not be used for pharmacy claims