How to Complete This Medical Claim Form

Please complete this form completely and attach an original fully itemized bill(s) along with any supporting documentation.

1. The Member or Authorized Person must complete the following sections of the form:
   • Member
   • Patient Information
   • Accident Information
   • Medicare Information
   • Other Health Insurance
   • Authorization/Release of Information/Assignment of Benefits

2. Authorization/Release of Information
   Your signature authorizes GEHA to obtain information to carry out our processing of the claim(s).

3. Assignment of Benefits
   Your signature authorizes GEHA to pay the Provider or Supplier directly. Attach itemized documents supporting payment made on any portion of this claim.

4. Submitting the Claim Form
   COVID test claims: When you have purchased a COVID test from a recognized online entity or retail distributor, you must attach the following to the completed claim form: An itemized statement with all description details, complete cost and proof of purchase. Mail to PO Box 21542, Eagan, MN 55121. If you need assistance with completing this form, please contact GEHA at 800.821.6136.

In-network medical claims: When you use a health care provider that is in GEHA's network, you will not have to fill out any claim forms in most cases. GEHA's in-network providers and facilities file claims for you as indicated on your ID card.

Out-of-network medical claims: If you use an out-of-network provider, the claim may be submitted by either you or by the provider. Federal regulations require that a claim submitted by a provider must be filed on a CMS-1500 form. If you need to submit a medical claim yourself and you have an itemized bill, please attach and mail to PO Box 21542, Eagan, MN 55121. If you need assistance with completing this form, please contact GEHA at 800.821.6136.
### Member Information (please print)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>MI</th>
<th>Subscriber ID Number</th>
</tr>
</thead>
</table>

### Patient Information – Complete this section only if claim is for a qualified dependent.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>MI</th>
</tr>
</thead>
</table>

### Accident Information – Complete this section only if claim is result of accident or work-related illness or injury.

- **Date of accident or first symptoms of illness?**
- **Where did the accident occur? (City/State)**
- **Is accident/illness related to employment?**
  - [ ] Yes
  - [ ] No

### Medicare Information – Complete this section only if patient is eligible for Medicare.

- **Medicare Number (include any alpha characters)**
- **Effective Date Part A**
- **Effective Date Part B**
- **Please attach copy of the “Explanation of Benefits” statement from your Medicare insurance carrier.**

### Other Health Insurance – Complete this section if yes, otherwise claim cannot be processed.

- **Name of Policyholder**
- **Policy Number**
- **Name of Insurance Company/Phone**
- **Number Street Address**
- **City**
- **State**
- **ZIP**

### Authorization/Release of Information

I authorize any insurance company, organization, employer, hospital physician, pharmacist or other health care provider to release any information requested with regard to this claim and the expenses reported. I certify that the information furnished in conjunction with this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to omit facts I know are important.

<table>
<thead>
<tr>
<th>Patient or authorized person’s signature</th>
<th>Date</th>
</tr>
</thead>
</table>

### Assignment of Benefits

I agree to assign benefits directly to the provider of services:

<table>
<thead>
<tr>
<th>Patient or authorized person’s signature</th>
<th>Date</th>
</tr>
</thead>
</table>

### THIS SECTION FOR PHYSICIAN OR SUPPLIER ONLY. If a detailed statement is available, please attach.

#### Provider Statement of Services Rendered

<table>
<thead>
<tr>
<th>Name and address of facility where services were rendered (if other than home or office)</th>
<th>Date Admitted</th>
<th>Date Discharged</th>
</tr>
</thead>
</table>

#### Diagnosis Code and Description

1. 
2. 
3. 
4. 

#### Date of Service (from/to) | Place of Service | CPT-4 Procedure Code | Description of Service | Charges | Days or Units |
|-----------------------------|------------------|----------------------|------------------------|---------|---------------|

#### Signature of Provider

<table>
<thead>
<tr>
<th>Signature of Provider</th>
<th>Total Charge</th>
<th>Amount Paid</th>
<th>Balance Due</th>
</tr>
</thead>
</table>

### Provider Information

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Tax ID Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Address</th>
<th>Telephone Number</th>
</tr>
</thead>
</table>