MEDICAL CLAIM FORM

luminare health℠

MAIL TO:
Address Indicated On
Your Identification Card

Instructions:

1. Please complete all sections
2. All itemized bills MUST be attached and include: Patient's name, Provider's name, diagnosis, dates of services and charge amount.
3. If you or a dependent are covered by another Plan (including Medicare), please submit the bill to the Primary Plan first. Then send our office a copy of the Explanation of Benefits along with the bill.

EMPLOYEE INFORMATION

Name (First, MI, Last)	Sex ☐ Male ☐ Female	Birthdate	Member Number
Home Address	City	State	Zip
Employer:	Date of Hire	Occupation	Date Last Worked

PATIENT INFORMATION

Patient Name (First, Middle, Last)	Relationship	Sex ☐ Male ☐ Female	Birthdate

Is the Patient Married? ☐Yes ☐No	Is the Patient a Full-time Student? ☐Yes ☐No	If yes, How Many Hours?	Date Last Attended?	Name and Address of School
Nature of Illness	Name, Address and Phone No. of Doctor Seen For This Illness			

IF CLAIM IS BASED ON AN ACCIDENT, COMPLETE THE FOLLOWING

Date and Time of Accident	Was Accident Work Related? ☐Yes ☐No	Place	How It Happened

SPOUSE INFORMATION

Name (First, MI, Last)	Sex ☐ Male ☐ Female	Birthdate	Soc. Sec. No.
Spouse's Employer Name	Address		Phone No.

OTHER INSURANCE INFORMATION

Do You or Your Dependents Have Other Coverage? ☐Yes ☐No	Type of Coverage? ☐ Single ☐ Family	Type of Plan? ☐ Group Health Plan ☐ Government Plan ☐ Medicare ☐ Other

Name of Person Covered by Other Insurance	Group Number	Soc. Sec. No.	Benefits ☐Medical ☐Dental ☐Vision ☐Other
Name and Address and Phone No. of Other Insurance Company			

AUTHORIZATION TO RELEASE INFORMATION --
I hereby authorize any Dentist, Physician, Hospital, Insurance Company, Organization, or Employer to release any information to Luminare Health for any oral or dental observation, treatment, services, or benefits rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

PATIENT'S SIGNATURE (PARENT IF MINOR) DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDERS --
I hereby authorize payment of benefits to any providers of service rendered or payable to me or on my behalf. A photocopy of this authorization shall be valid as the original

PATIENT'S SIGNATURE (PARENT IF MINOR) DATE