



HEALTH INSURANCE CLAIM FORM
 Claim services provided by: HealthAmerica
To precertify call (800) 755-1135

MAIL TO:
 HealthAmerica
 PSU HealthPass / PSU Plan A
 P.O. Box 7132
 London, KY 40742

PLEASE REFER TO INSTRUCTIONS ON THE BACK OF THIS FORM. PATIENT AND/OR INSURED FILLS OUT BLUE INFORMATION. PHYSICIAN OR SUPPLIER FILLS OUT RED INFORMATION.

NOTE: Any person who knowingly files a statement containing any false information or conceals information for the purpose of misleading will be subject to disciplinary action.

1. PLANA HEALTHPASS/HEALTHASSURANCE PPO <input type="checkbox"/> Active <input type="checkbox"/> Retiree		1a. MEDICARE COVERAGE <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> None		1b. INSURED'S I.D. NUMBER (From Plan A or HealthPass/Health Assurance I.D. Card)	
2. PATIENT'S NAME (Last, First, Middle Initial)		3. PATIENT'S BIRTHDATE MM : DD : YY Sex M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last, First, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY STATE	
ZIP CODE TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student Student		ZIP CODE TELEPHONE (Include Area Code) ()	
9. IS THERE ANOTHER HEALTH INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9a-e</i>		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP NUMBER (From I.D. card)	
a. OTHER INSURED'S NAME (Last, First, Middle Initial)				a. INSURED'S DATE OF BIRTH SEX MM : DD : YY M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S POLICY OR GROUP NUMBER				b. EMPLOYER'S NAME The Pennsylvania State University	
c. OTHER INSURED'S DATE OF BIRTH SEX MM : DD : YY M <input type="checkbox"/> F <input type="checkbox"/>				c. INSURANCE PLAN NAME OR PROGRAM NAME PSU Health Benefits Plan	
d. OTHER EMPLOYER'S NAME OR SCHOOL NAME		e. OTHER INSURANCE PLAN NAME OR PROGRAM NAME			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE-- I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE -- I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNATURE _____	
14. DATE OF CURRENT: MM : DD : YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM : DD : YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM : DD : YY TO MM : DD : YY	
19. MEDICAL SPECIALTY		19a. MEDICAL LICENSE # STATE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM : DD : YY TO MM : DD : YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to item 24E by line)				20. OUTSIDE LAB? \$CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
1. _____		3. _____		22.	
2. _____		4. _____		23. PRECERTIFICATION NUMBER	
24. A DATE(S) OF SERVICE FROM MM : DD : YY TO MM : DD : YY		B Place of Service C Type of Service		D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
E DIAGNOSIS CODE		F \$ CHARGES		G DAYS OR UNITS	
H AMOUNT PAID BY OTHER INSURANCE		I AMOUNT PAID BY PATIENT			
1.					
2.					
3.					
4.					
5.					
6.					
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
SIGNED _____ DATE _____				PIN # _____ GRP# _____	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

IMPORTANT: INSTRUCTIONS FOR COMPLETING THIS FORM:

To ensure prompt and accurate processing of your Plan A or HealthPass/HealthAssurance claim, all of the required information must be included. Any receipts or attachments to this claim form that are smaller than the form, should be taped (NOT STAPLED) to an 8 1/2" x 11" sheet of paper. The INSURED'S name and ID number should be indicated on all attachments.

IF YOU HAVE ANY QUESTIONS ABOUT COMPLETING THIS FORM, PLEASE CALL MEMBER SERVICES AT 814-231-8970 OR (800) 366-6433. MAIL COMPLETED FORMS TO:

HealthAmerica
PSU HealthPass / PSU Plan A
P.O. Box 7132
London, KY 40742

BLOCK #**INSTRUCTIONS**

1. Indicate whether the patient is enrolled in the PSU Plan A or the HealthPass/HealthAssurance PPO and if the INSURED is an active employee or retired.
- 1a. Indicate Medicare coverage; Part A (hospital), Part B (physician), or None.
- 1b. INSURED'S ID number is indicated on the Plan A or HealthPass/HealthAssurance ID card.
2. The full name of the patient; last name first.
3. The patient's date of birth, MM=month; DD=day; YY=year. The gender of the patient is also required M=male; F=female.
4. INSURED'S name - The full name of the policy holder as indicated on the ID card.
5. Patient's address - Full current mailing address and telephone number of the INSURED.
6. Patient relationship to INSURED: Indicate whether the patient is the INSURED (self) or a covered dependent (spouse or child).
7. INSURED'S address - The full and current mailing address and telephone number of the INSURED (policy holder).
8. Patient Status - Indicate the patient's marital and employment status.
- 9 a-c. Other insurance information - If the patient is covered by any other insurance plan (including Medicare) in addition to the PSU health plan, this information must be indicated. **FAILURE TO PROVIDE THIS INFORMATION ON THE CLAIM FORM MAY DELAY PROCESSING AND PAYMENT FOR ELIGIBLE SERVICES.**
- 10 a-c. Patient's condition - If the services claimed are related to an accident or injury that occurred at work, home, or during travel, the appropriate "yes" block must be checked. **FAILURE TO CHECK A "YES" OR "NO" BLOCK IN 10A THROUGH 10C MAY DELAY PROCESSING AND PAYMENT FOR ELIGIBLE SERVICES.**
- 11 a-c. INSURED'S policy group number. This number is indicated on the Plan A or HealthPass/HealthAssurance ID card. This number will expedite processing. The INSURED'S gender (male or female) and date of birth must be indicated (if not already indicated in block #3).
12. Patient Signature - This block must be signed by the patient and/or INSURED for the claim to be processed. The signature authorizes the PSU health plan administrator, HealthAmerica, to obtain medical information necessary to process the claim.
13. Assignment of payable benefits - If payment is to be made to the PROVIDER of services, this block must be signed by the patient/INSURED. **DO NOT SIGN THIS BLOCK IF PAYMENT IS TO BE MADE DIRECTLY TO THE INSURED AND NOT TO THE PROVIDER!**

14-33. THE INFORMATION REQUIRED FOR BLOCKS 14-33 MUST BE OBTAINED FROM OR PROVIDED BY THE PHYSICIAN, SUPPLIER, FACILITY, OR OTHER PROVIDER OF HEALTH CARE SERVICES. IF THE PROVIDER DOES NOT COMPLETE THE CLAIM FORM, THE FOLLOWING INFORMATION MUST BE SUBMITTED BY THE PATIENT/INSURED:

The provider's "Super Bill" form OR an itemized statement of services provided, including:

1. Date(s) of service.
2. Place of service (physician office, outpatient surgery center, emergency room, etc.).
3. Procedure code - A 5-digit numerical code for the medical procedure performed (from Current Procedure Terminology (CPT) Manual). Unspecified procedure codes (those ending in 99) will not be accepted.
4. Diagnosis code - A 3 to 5 character code indicating the diagnostic reason for performing the procedure (from ICD-9 manual).
5. The charges for the claimed services.
6. Signature of the provider of services.

NOTE: Cash register receipts and incomplete statements will not be accepted. Incomplete forms will be returned for additional information.

PRECERTIFICATION PROGRAM:

All nonemergency inpatient hospital confinements for individuals not covered by Medicare must be precertified PRIOR TO ADMISSION. In order to obtain precertification, including the appropriate length of stay in the hospital, your physician, the hospital, you or a family member must call (800) 755-1135. Extensions to precertified hospital confinements must also be certified. In cases where an emergency is involved, precertification must take place within two business days of admission. It is your responsibility to obtain precertification. Benefits will be reduced if the precertification program is not used.