AmeriHealth NEW JERSEY

**Please Mail To:**
AmeriHealth Insurance Company
P.O. BOX 41574
Philidelphia, PA 19101-1574

# AmeriHealth New Jersey Copay Reimbursement Form

Please mail to:
**AmeriHealth New Jersey** | PO Box 41574, Philadelphia, PA 19101

## Member/Patient

**I.**

| 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<br>☐ Self ☐ Spouse ☐ Child<br>☐ Handicapped dependent ☐ Other | Sex<br>☐ Male<br>☐ Female | Birth Date<br>___/___/_____ |

## Other Insurance

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

**II.**

| Policyholder's Name | Birth Date | Employment Status of Policyholder | |
|---|---|---|---|
| | ___/___/_____ | ☐ Active ☐ Disabled<br>☐ Retired Effective Date: ___/___/_____ | |
| Relationship of Policyholder to Member<br>☐ Self ☐ Spouse ☐ Child ☐ Other _____ | Other Insurance Carrier's Name | Identification No. | Effective Date<br>___/___/_____ |

| Type(s) of Coverage ☐ Hospitalization ☐ Medical-Surgical ☐ Dental ☐ Vision ☐ Drug<br>☐ Major Medical ☐ Other (specify) _____ _____ _____ |
|---|
| Contract Covers<br>☐ Policy Holder Only ☐ Policy Holder and Spouse ☐ Policy Holder and Child(ren) ☐ Family |

## Authorization

**III.**

I certify that the information 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 New Jersey all medical or other information requested for the processing of this claim. I hereby agree to reimburse AmeriHealth New Jersey in full should this claim be incorrectly paid. Any person who knowingly and with intent to defraud any insurance company or other person who 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 a person to criminal and civil penalties.

| _____ | _____ | _____ |
|---|---|---|
| Member Signature Date | (Area Code) Home Phone | (Area Code) Work Phone |