AmeriHealth NEW JERSEY

Send this request for benefits to:
AmeriHealth Processing Services
PO Box 41574
Philadelphia, Pa 19010-1574
Remember:
To avoid delays be sure Employee's social security# is provided

Point of Service Claim Form

INFORMATION WE NEED FROM YOU (TYPE OR PRINT)

Section A
THIS SECTION MUST BE SIGNED BEFORE A CLAIM MAY BE PROCESSED

I am choosing to receive covered healthcare services for myself or a dependent outside of the designated referral system. I understand that by using non-referred providers, I will be subject to a deductible, coinsurance and other co-payments, as specified in the AmeriHealth contract.

Signed - Employee or Spouse **X**	Date

Section B

1. Patient's name (First, M.I., Last)		ID#	
2. Patient's address *(If different from employee)*			
3. Patient's date of birth (month/day/year)	4. Patient's sex ☐ Male ☐ Female	5. Patient's relation to employee ☐ Individual ☐ Employer	
6. Subscriber's name (First, M.I., Last)		ID#	
7. Subscriber's Address		Home Telephone#	Business Telephone#
Street			
City		State	Zip Code
8. Was condition related to: A. Patient Employment ☐ Yes ☐ No	B. Accident ☐ Yes ☐ No	If an Accident Date__/__/__ Time ☐ AM ☐ PM	Description (How and Where)
9. Subscriber's SS#	10. Group#	10A. Group name (Employer's company name)	
11. Is patient covered by any other health plan? ☐ Yes ☐ No If yes, Name of policy holder		Name and address of insurance company	
Policy #			
12. Is patient covered by medicare? ☐ Yes ☐ No		13. Is child a full-tme student? ☐ Yes ☐ No	
I authorize the release of any information necessary to process this request. 14. Signed (patient or parent if minor) **X**			

INFORMATION TO BE COMPLETED BY PHYSICIAN

Section C

15. Name and address of facility where services rendered *(if other than home or office)*

16. Date first consulted you for this condition

17. Diagnosis, or nature of illness or injury. Relate diagnosis to procedure in column by reference to #s 1,2,3 etc. Or DX code

18. A. Place of Service	B. Date of Service	C. Fully describe procedure, medical services, or supplies for each date: Procedure Code	Mod 1	Mod 2	Explain unusual services or circumstances	D. Diagnosos Code or Units	E. Charges	

19. Your patient's account #	20. Physician or supplier's name	22. Total Charges	
21. Enter the taxpayer ID # to be used for 1099 Reporting purposes. You are required by law to furnish your Taxpayer ID #.	Address	23. Amount Paid	
	Zip Code	24. Balance Due	
Taxpayer ID #	Telephone #	Date	

25. Signature of physician or supplier **X**

Instructions

EMPLOYEE

1. Each time you request benefits sign section a and complete section b (items 1 through 14) on the reverse side of this form.Use a separate benefit request form for each member of the family.
2. Ask your doctor, hospital or supplier to complete (section c the physician or Supplier information items 15 - 25) or attach itemized bills.

Itemized bills should include:

Doctor's name & address
Patient's name
Date of service
Condition being treated/diagnosis
Charge for service
Type of service

IF YOU HAVE ANY QUESTIONS, CALL: 1-800-422-2457

DOCTOR, HOSPITAL OR SUPPLIER

1. Complete items 15 through 25 on the benefits request form using current cpt procedure and icd-cm diagnosis codes.

2-DIGIT PLACE OF SERVICE CODES

(THE CURRENT 2-DIGIT PLACE OF SERVICE CODE MUST BE USED ON ALL CLAIMS SUBMISSIONS)

11 Office	51 Inpatient Psychiatric Facility
12 Home	52 Psychiatric Facility Partial Hospitalization
21 Inpatient Hospital	53 Community Mental Health Center
22 Outpatient Hospital	54 Intermediate Care Facility/Mentally Retarded
23 Emergency Room (Hospital)	55 Residential Substance Abuse Treatment Facility
24 Ambulatory Surgical Center (Asc)	56 Psychiatric Residential Treatment Facility
25 Birthing Center	61 Comprehensive Inpatient Rehab Facility
26 Military Treatment Facility 31 Skilled Nursing Facility (Snf)	62 Comprehensive Outpatient Rehab Facility
32 Nursing Facility	65 End Stage Renal Disease Treatment Center
33 Custodial Care Facility	71 State Or Local Public Health Center
34 Hospice	72 Rural Health Clinic
41 Ambulance (Land)	81 Independent Laboratory
42 Ambulance (air or water)	99 Other Unlisted Facility

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material 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 person to criminal and civil penalties. PROVIDERS: By signing this document, you swear or affirm that the services or materials for which claim is being made were necessary and were, in fact, furnished.

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