AmeriHealth NEW JERSEY

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

Claim Form (see reverse side for instructions)

MEMBER/PATIENT

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 ☐ Self ☐ Spouse ☐ Child ☐ Handicapped dependent ☐ Other	Sex	DOB ___/___/___

OTHER INSURANCE

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

Policyholder's Name	DOB ___/___/___	Zip Code
Employment Status of Policyholder ☐ Active ☐ Disabled ☐ Retired ☐ Effective Date: ___/___/___		
Relationship of Policyholder to Member ☐ Self ☐ Spouse ☐ Child ☐ Other		
Other Insurance Carrier's Name	Identification No.	Effective Date: ___/___/___

Type(s) of Coverage ☐ Hospitalization ☐ Medical-Surgical ☐ Dental ☐ Vision ☐ Drug ☐ Major Medical ☐ Other (specify) _____

Contract Covers ☐ Policyholder Only ☐ Policyholder and Spouse ☐ Policyholder and Child(ren) ☐ Family

Is the PATIENT entitled to benefits under MEDICARE HOSPITALIZATION Insurance (Part A)?
☐ No ☐ Yes Effective Date ___/___/___ Medicare ID Number_____

Does the PATIENT receive benefits under MEDICARE MEDICAL Insurance (Part B)?
☐ No ☐ Yes Effective Date ___/___/___ Medicare ID Number_____

If you answered "yes" to either of the above, give employment status of the Member listed in Part "I": ☐ Active ☐ Retired ☐ Disabled

PATIENT'S CONDITION

Describe conditions for which you are requesting benefits at this time:

Type of Injury or Illness	Name of Doctor Treating Injury/Illness	Date of First Symptoms
A.		
B.		

Were Services Related To Hospitalization? ☐ No ☐ Yes If yes, please fill in boxes below:

Date of Admission ___/___/___	Date of Discharge ___/___/___
Hospital Name _____	Admitting Physician _____

Were Expenses Due To An Accident? ☐ No ☐ Yes If yes, give type/place of accident:

Date of accident 2/1/3 ☐ Work ☐ Auto ☐ Other (specify) _____

Is this claim for prescription drugs? ☐ No ☐ Yes If yes, please give: Pharmacy Name _____ Address _____

NDC Number (obtain from Pharmacist): _ _ _ _ _ - _ _ _ _ - _ _

AUTHORIZATION

I certify that the information provided 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 all medical or other information requested for the processing of this claim. I hereby agree to reimburse AmeriHealth in full should this claim be incorrectly paid. 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 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 person to criminal and civil penalties.

Member Signature	Date 2/3/4	Home Phone	Work Phone

Instructions

If your provider is participating in AmeriHealth, the provider will submit a claim for you. This claim form should only be submitted when you use a non-participating AmeriHealth provider who does not submit a claim for you.

1. Please attach itemized bills to this claim form. These bills should include the following information:
   - Name, address, and telephone number (on official bill head) of the PROVIDER rendering the service or supplying the item.
   - PATIENT'S full name
   - DESCRIPTION of each service rendered or item supplied
   - DATE AND AMOUNT CHARGED for each service rendered or item supplied
   - DIAGNOSIS of ailment

2. Please be sure that a PHYSICIAN'S MEDICAL CERTIFICATION accompanies bills for:
   - Purchase or rental of medical equipment

3. When you are submitting expenses for more than one family member, please use a SEPARATE claim form for each person.

4. Please complete the claim form carefully, and be sure to include the information requested above. This will help to avoid unnecessary delays in processing your claim.

5. Prescription drug purchases made at network pharmacies do not require you to submit a claim form. The pharmacist will file the claim for you, and any resulting benefit payments will be made directly to you. If you purchase your prescription drug at a non-network pharmacy, you may still be entitled to reimbursement for a portion of your prescription drug expenses by completing Section III of this claim form. Be sure to include itemized receipts for each prescription. Remember to ask your pharmacist for the NDC number of the drug you purchase, and record that number in Section III on the front of this form.

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