

## Physician or Supplier Information

<b>1. DATE OF CURRENT:</b> MM   DD   YR   <b>ILLNESS (1st Symptom: OR INJURY (Accident) OR PREGNANCY (LMP))</b>			<b>2. IF CLAIMANT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE:</b> MM   DD   YR			<b>3. DATES PATIENT TOTALLY DISABLED:</b> MM   DD   YR      MM   DD   YR TO					
<b>4. NAME OF REFERRING PHYSICIAN:</b>			<b>5. I.D. # OF REFERRING PHYSICIAN:</b>			<b>6. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:</b> MM   DD   YR      MM   DD   YR TO					
<b>7. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: (relate items 1,2,3 OR 4 TO ITEM 8E BELOW)</b> 1. _____      3. _____ 2. _____      4. _____											
<b>8. A. DATE(S) OF SERVICE FROM TO</b> MM DD YR      MM DD YR		<b>B. PLACE OF SERVICE</b>	<b>C. TYPE OF SERVICE</b>	<b>D. PROCEDURES, SERVICES, OR SUPPLIES</b> CPT CODE      MODIFIER	<b>E. DIAGNOSIS CODE</b>	<b>F. \$ CHARGES</b>	<b>G. DAYS OR UNITS</b>	<b>H. EPSDT</b>	<b>I. EMG</b>	<b>J. COB</b>	<b>K</b>
1.											
2.											
3.											
4.											
<b>9. FEDERAL TAX ID#:</b> SSN      EIN <input type="checkbox"/> <input type="checkbox"/>			<b>10. PATIENT ACCOUNT #:</b>			<b>11. TOTAL CHARGE</b>		<b>12. AMOUNT PAID</b>		<b>13. BALANCE DUE</b>	
<b>14. SIGNATURE OF PHYSICIAN OR SUPPLIER:</b> (I certify that the information furnished by me in support of this claim is correct.)  X _____				<b>15. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED: (if other than home or office.)</b>				<b>16. PHYSICIAN'S/SUPPLIER'S BILLING NAME, ADDRESS AND TELEPHONE #:</b>			

### HOW TO FILE A CLAIM

Complete the **Employee and Patient** sections on the reverse side of this form.

HAVE THE PATIENT'S PHYSICIAN COMPLETE THE "PHYSICIAN OR SUPPLIER INFORMATION" SECTION ABOVE OR ATTACH ITEMIZED\* BILLS/PRESCRIPTION DRUG RECEIPTS TO THIS CLAIM FORM.

\* AN ITEMIZED BILL CONSISTS OF:

- Employee's Name and ID Number
- Patient's Name
- Provider Name, Address and Tax ID Number
- Date(s) of Service
- Type(s) of Service
- Charge for each Service
- Diagnosis/Procedure Codes

**FORWARD COMPLETED CLAIM FORM AND RELATED BILLS TO:**

**MMEHT**  
**60 Community Drive**  
**Augusta, ME 04330-9486**



# Maine Municipal Employees Health Trust

60 Community Drive  
Augusta, ME 04330-9486  
(207) 621-2645

1-800-852-8300 (In Maine)

## MEDICAL CLAIM FORM

### PLEASE TYPE OR PRINT

Please complete this form as thoroughly as possible. Submitting a completed form along with itemized bills (see reverse side), will eliminate delays in processing your claim.

#### PLEASE NOTE REVERSE SIDE BEFORE COMPLETING THIS FORM

1. Insured's (Employee's) Name and Address		A. Date of Birth / /	B. Employee's Soc. Sec. No.
2. Patient's Name	A. Date of Birth / /	B. Patient's relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	C. Employee's Phone Number
3. 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/Injury? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No		4. If this claim is related to an accident/injury, please answer the following: Date of Accident/Injury: _____ How accident/injury happened: _____ Where accident/injury happened: _____	
5. If dependent is over 19, do you provide at least 50% support? <input type="checkbox"/> Yes <input type="checkbox"/> No		6. Does patient have other insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES: Phone Number: _____ Policyholder: _____ Plan Name: _____ Address: _____ Policy No: _____ Effective Date: _____	
AUTOMATIC PAYMENT TO PROVIDER UNLESS ITEMIZED BILL IS CLEARLY MARKED PAID.			
7. AUTHORIZATION: The above answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including Veteran's Administration or governmental hospital, any medical service organization, any insurance company or other institution or organization, to release to each other any medical or other information, including benefits paid or payable, concerning this or other disabilities. A photocopy of this authorization shall be valid as the original.			
Signed: _____		Date: _____	

**If your primary coverage is through other insurance, such as Medicare, Champus, MaineCare, or Blue Cross be sure to send a photocopy of the Explanation of Benefits (EOB) along with the corresponding itemized bills.**