



Claim Form for Medical Benefits

TO BE COMPLETED BY THE EMPLOYEE

- 1. Employee's Name (first, middle, last) Date of Birth (Month, Day, Year)
2. Employer's Name Group #
3. Employee's Home Address (Street, City, State, Zip) Is this a new address?
4. Employee's Social Security #: 5. Telephone No.
6. (a) Are any of your dependents including your spouse presently employed? (b) Name and Social Security No. of Employed Dependent Relationship Name/Address of Employer (including Zip Code and Phone No.)
7. Are any pharmacy expenses covered under another employer group, union, welfare plan, school, or program? If "Yes," complete the following: (a) Name and address of company or organization (i.e, employer, union, association, etc.) sponsoring the plan or program (b) Name and address of insurance carrier (c) Policy No.

COMPLETE QUESTION #8 ONLY IF CLAIM IS FOR A SPOUSE OR DEPENDENT CHILD.

- 8. If expenses on this claim are for medical services for an eligible dependent, answer the following: (a) Dependent's Name (First, Middle, Last) (b) Date of Birth (Mo./Day/Year) Sex: M/F (c) Relationship to Employee: Spouse, Child under 19, Child 19 or over (d) If Dependent Child is 19 or over, answer the following: Full Time Student, Name of School, Employed Full Time, Employed Part Time, Unemployed, Disabled
9. If any of the medical expenses were a result of an accident, complete the following: (a) When did the accident happen? Date at (hour) am/pm (b) Where did the accident happen? City State (c) Did the accident occur at work? Yes/No (c) Supply a brief description of the accident
10. If any of the expenses included on the claim are covered under Medicare, complete the following: (a) Is the patient covered under MEDICARE Hospital insurance Part A Yes/No Eff. Date (b) Is the patient covered under MEDICARE Hospital insurance Part B Yes/No Eff. Date

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any physician, hospital, pharmacy, insurance company, employer, third party payer or organization to release any information regarding the history, treatment, or benefits payable concerning this claim to SummaCare or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim.

I certify that the information submitted by me is true and correct and I understand that falsifying a claim can lead to disciplinary action, including discharge.

Employee's Signature Date

Any person who knowingly and with intent to defraud any insurance company or other person files a statement 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.

INSTRUCTIONS FOR FILING A CLAIM

1. **Complete the employee's section on the reverse side.**
- Use a separate claim form for EACH member of the family for each claim submitted
 - Complete the Authorization Section (Section 9) on the reverse side.
 - Have the pharmacist complete the Pharmacist's Statement below.
 - All bills for related expenses should be submitted at the same time.

Send completed claim form and itemized bills to:
SummaCare
 P.O. Box 3620
 Akron, OH 44309-3620
 (330) 996-8550
 (800) 996-8851

PHARMACY RECEIPT FOR EACH DRUG MUST BE ATTACHED

Patient's Name

PHARMACIST'S STATEMENT

PHARMACIST: Please list only those DRUGS and MEDICINES dispensed under prescription by order of a legally qualified physician. Please submit a separate form for each family member.

Purchase Date	Prescription No.	Check if Refill	Quantity	Description	Prescribing Physician	Charge to Patient
TOTAL CHARGES						

I HEREBY CERTIFY THAT EACH OF THESE LISTED ITEMS WAS DISPENSED AS WRITTEN BY ORDER OF THE ABOVE NAMED PHYSICIAN(S) TO:

Name of Pharmacy _____ Telephone No. _____

Address _____

Pharmacist's Name _____ License No. _____

Pharmacist's Signature _____ Date _____

SummaCare Member Services (330) 996-8700 or (800) 996-8701
www.summacare.com