## AMERICORPS BENEFITS MEDICAL CLAIM FORM



DARTA OLAIM FORMINO	TRUCTIONS					
PART A – CLAIM FORM INS			hillo provide	Note: Hereins 11 11	lo oro NOT:	9. If you have a Confident of Condition
PLEASE PRINT  1. Read both sides of this form.	Attach all original itemized bills provid complete information on:			Balance Due Statements		If you have a Certificate of Creditable     Coverage from your prior medical
Read both sides of this form.     Completely fill out Sections B-F.	Doctor's Name and Address     Doctor's Tay Identification Number			Explanation of Benefits		coverage, please attach it to your completed Medical Claim Form and send it
(Part E is optional.)	<ul><li>Doctor's Tax Identification Number</li><li>Patient Name</li></ul>			6. If your medical provider sends your bill or		to:
Sign and date Section F.	Diagnosis Code ICD-9			claim to us, make sure an itemized bill is included.		
Remember to provide your Social Security	Date of Service     Charges/Cost of each treatment			Moorestown, N.I 08057		
Number.	Procedure Codes CPT-4			<ol><li>Sign Section E if you want benefits paid to your medical provider.</li></ol>		800-359-7475
DART R. INCHES VOLUM	Place of Ser		VI	•		Make a copy of this form for your records.
PART B – INSURED VOLUN				DTU	COCIAL OF	CUDITY NUMBER
INSURED VOLUNTEER'S NAME (LAST, f	rirst, middie) L	Male	DATE of BI		YY SOCIAL SE	CURITY NUMBER
		☐ Female	IVIIVI	/ /	''	
STREET ADDRESS CITY STATE ZIP CODE						
PHONE NUMBER ORGANIZATION NAME ORGANIZATION GROUP NUMBER						
DOES THE INSURED VOLUNTEER HAVE	E OTHER HEALT	H BENEFIT	COVERAGE?	P □ YES	NO	
				_	_	TECTIVE DATE:
IF <b>YES</b> , PLEASE PROVIDE THE INSURAL PART C – CLAIM INFORMAT		ROGRAM NA	AME, THE PO	LICY OR GROUP	NUMBER, AND THE EFF	-ECTIVE DATE:
	TREATMENT TH	E DECILIT	OE OCCUBAT	TIONAL ILL NESS	OD IN HIDV2 WHEN D	DID THE ACCIDENT OR ILLNESS OCCUR?
IS THE CLAIM FOR AN.	IKEAIWENI IN	E KESULI (	OF OCCUPAT	IONAL ILLNESS	OK INJUKT? WHEN D	MM DD YY
☐ ACCIDENT? OR ☐ ILLNESS?		☐ YE		NO		
PLEASE EXPLAIN WHAT YOU WERE T HOW THE ACCIDENT HAPPENED. (If yo						VIDE DETAILS OF WHEN, WHERE AND
HOW THE ACCIDENT HAFFENED. (If yo	ou neeu auuniona	aı əpace, dil	avii a siieel 0	n paper to this it	) iii.)	
HAVE YOU HAD PRIOR TREATMENT FO	OR THIS CONDITI	ION?	☐ YES	□NO		
IF YOUR ANSWER IS YES, WHAT WAS	THE DATE OF TR	REATMENT?	·	MM DD	YY	
PART D - PRESCRIPTION D	<b>RUG INFOR</b>	MATION	I			
NAME OF CURRENT MEDICATION(S)				CONDITION BEING TREATED		
NAME OF CURREN		- /			CONDITION D	
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## **FRAUD NOTICE**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON SUBMITS AN INSURANCE APPLICATION OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE COMMITTING A CRIME ANY MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES.

## The laws of some states require us to furnish you with the following notice:

**California and Texas:** Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Hawaii:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of loss or benefit is a crime punishable by fines or imprisonment, or both.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Pennsylvania:** 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.