MOUNTAIN HEALTH CO-OP

IMPORTANT: PLEASE READ THE FOLLOWING BEFORE COMPLETING THIS FORM. PLEASE PRINT IN INK.
Please submit one claim form per patient. All questions must be answered for prompt processing. Attach itemized bills from your provider. **Note: See your Plan documents for applicable claims filing requirements.**

SEND THIS COMPLETED CLAIM FORM TO: Mountain Health CO-OP
Claims Administrator
P.O. BOX 30311
SALT LAKE CITY, UT 84130
CUSTOMER SERVICE NUMBER: 1-800-299-6080
CUSTOMER SERVICE FAX NUMBER: 1-800-781-6260

Note: This form only needs to be completed if the provider is not submitting a claim on your behalf or you are requesting reimbursement for out-of-pocket expenses.

PARTICIPANT DATA					
NAME OF PLAN			PLAN ID	WORK PHONE ( )	HOME PHONE ( )
PARTICIPANT NAME	LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER	MEDICAL RECORD #
HOME ADDRESS	STREET		CITY	STATE	ZIP-CODE
MARITAL STATUS ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated			OTHER COVERAGE? ◯ Yes ◯ No If Yes, complete section below		

PATIENT DATA					
PATIENT NAME	LAST	FIRST	MIDDLE	SEX ◯ Male ◯ Female	PHONE NUMBER
DATE OF BIRTH	AGE			DISABLED DEPENDENT ◯ Yes ◯ No	

RELATIONSHIP TO EMPLOYEE ☐Husband ☐Wife ☐Domestic Partner ☐Son ☐Daughter ☐Other (Describe)_____

If this patient is a dependent child, age 18 or older, is he/she a full-time student? ☐Yes ☐ No If yes, name of school:_____

Were these charges incurred as a result of an on-the-job illness or injury? ☐Yes ☐No Other accident ☐Yes ☐No
If the claim is the result of any kind of accident or injury, complete the following information: Date:_____ Time:_____
Description of what happened:_____

OTHER COVERAGE DATA – PLEASE READ INSTRUCTIONS ON BACK	
IS THIS PATIENT EMPLOYED? ◯ Yes ◯ No	IF YES, GIVE NAME AND ADDRESS OF EMPLOYER

IS THIS PATIENT OR ANY OTHER FAMILY MEMBER COVERED BY OTHER HEALTHCOVERAGE OR PLAN? ◯Yes, ◯No Complete Section

Name of Insured or Participant	Name/Address of Insurance Company or Plan	ID Number	Group Number

IS THE PATIENT COVERED BY MEDICARE? ☐Yes ☐No

AUTHORIZATION SIGNATURE FOR INFORMATION RELEASE: I hereby authorize Mountain Health CO-OP, its third party administrators, my plan, and any health care provider that provided services in connection with this claim to disclose to Mountain Health CO-OP, its third party administrators, and any other source of coverage for those services, medical records and information pertaining to the services and patient identified in this claim, for the purpose of adjudication and payment of the claim. I understand that treatment, payment, enrollment, eligibility for benefits may not be conditioned on my providing or refusing to provide this authorization. This authorization is effective immediately and shall remain in effect for one year, unless a different date is specified here_____. This authorization may be revoked by the patient at any time, effective upon receipt, except to the extent that a disclosing party or others have acted in reliance upon this authorization. I understand that the recipient of information may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. A copy of this authorization is as valid as the original. The patient has a right to a copy of this authorization.

PATIENT/PARTICIPANT SIGNATURE: (Parent or guardian, if minor)	DATE:

PROVIDER INFORMATION (OPTIONAL)

HAS UTILIZATION MANAGEMENT BEEN CONTACTED FOR PRECERTIFICATION? ☐Yes ☐No If yes, Authorization Number:_____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: RELATE ITEMS 1, 2, 3 OR 4 TO THE DIAGNOSIS CODE BELOW BY ENTERING THE ITEM NUMBER FOR EACH SERVICE
1. _____ 2. _____ 3. _____ 4. _____

DATE(S) OF SERVICE		PLACE OF SERVICE	PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS/ MODIFIER	DIAGNOSIS CODE	FULL DESCRIPTION OF PROCEDURE/SERVICE	DAYS/ UNITS	CHARGE AMOUNT
FROM	THROUGH						
MO | DY | YR	MO | DY | YR						
| |	| |						
| |	| |						
| |	| |						

PROVIDER FEDERAL TAX I.D. NUMBER ☐SSN ☐EIN	PATIENT'S ACCT NUMBER	TOTAL CHARGES $	AMT PAID $	BALANCE DUE $

NAME, SIGNATURE, CREDENTIALS OF TREATING PHYSICIAN/SUPPLIER	PROVIDER BILLING NAME, ADDRESS, ZIP CODE AND PHONE#
PRINTED NAME:_____CREDENTIALS_____ SIGNED:_____DATE:_____	

HOW TO FILE YOUR CLAIM

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, OR OMITTING A MATERIAL FACT, MAY BE SUBJECT TO CIVIL OR CRIMINAL PROSECUTION AND PENALTIES.

This form is designed to help you file a claim for health care services received by you or an enrolled family member. If a doctor, hospital or other healthcare provider has already filed a claim directly with Mountain Health CO-OP on your behalf, please do not submit a Member Medical Claim Form for the same services. Please see your Plan documents for applicable claim filing requirements.

1. Complete the Participant Data and Patient Data sections of the claim form.
2. See instructions below regarding the Other Coverage Data section.
3. Complete and sign the Authorization section. Either have the provider complete the Provider Information section, or attach itemized bills provided by the provider. Each bill/receipt must include:
   - The name of the patient
   - Date expenses were incurred
   - Nature of encounter (i.e. office visit, x-ray, etc.)
   - Any other information your Plan requires.
4. For reimbursement of any out-of-pocket expenses you incurred, you must include a copy of a receipt from the provider, and evidence of your payment to the provider, such as a credit card receipt.
5. Send the completed claim form, itemized bills and attachments to:

   Mountain Health CO-OP
   Claims Administrator
   P.O. BOX 30311
   SALT LAKE CITY, UT 84130

Note: Please be aware that if the provider holds a contract to provide services for your Plan, payment of a claim will always be made to the provider, even if you paid the provider directly. In that circumstance, you will need to seek reimbursement from the provider.

INSTRUCTIONS FOR OTHER COVERAGE

If the patient has coverage under any other plan, in addition to the Plan administered by Mountain Health CO-OP, you may be able to receive benefits under both plans. This may happen if both spouses or domestic partners (where applicable) work and both carry family coverage through their respective employers or have other coverage. If you filed a claim with the other coverage, you will need to submit the explanation of benefits or other communication from the other coverage showing their adjudication of the claim, in addition to this Claim Form and copies of itemized bills and receipts.

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