PeakHealth

Member Claim Form

Please see reverse side before filing your claim and complete all required information below.

Patient Member ID:	**Group Number:**	
Patient Information (Last, First, MI):	**Date of Birth (MM/DD/YYYY):**	
Home Address:		
City, State, Zip:	**Phone Number:**	
Gender: Male Female	**Relationship to Subscriber:** Subscriber/Policyholder Spouse/Partner Child Other Dependent	
Subscriber Information (Last, First, MI):	**Date of Birth (MM/DD/YYYY):**	
Home Address:		
City, State, Zip:	**Phone Number:**	
Date of Service:		
Diagnosis: What is the illness or injury?		
For services out of the country, please explain where services were rendered (Office, ER, Urgent care, Hospital, Clinic, Pharmacy) **and explain nature of injury or illness.**		
Other Insurance Coverage Information Is the patient covered by another group health plan? ☐ Yes ☐ No		
If yes, please complete the following:		
Policy Holder Name (Last, First, MI):	**Policy Holder Date of Birth (MM/DD/YYYY):**	
Other Insurance Company Name:	**Policy ID #:**	**Group #:**
If accident, give date:	**Type of Accident:** ☐ Work ☐ Auto ☐ Other	

By signing below, I am stating that the information above is correct. Any person who knowingly files a statement of claim containing any misrepresentation of any false, incomplete, or misleading information, may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature: _____ Date: _____
(Patient or Authorized Representative)

Signature: _____ Date: _____
(Subscriber/Policy Holder)

How to request benefits:

1. Complete this form when your doctor does not file the claim for you. You should send this completed claim form as soon as possible after care. Check your plan coverage for specific deadlines to submit your claim.

2. Complete all areas of the Claim Form before returning the form to Peak Health. If benefits are to be claimed for more than one covered member, a separate claim must be submitted for each member.

3. Include the itemized bill you received from your doctor. It must include:

   Name, address, and tax ID number of provider (doctor, hospital, laboratory, ambulance service, etc.)
   Name of patient
   Service provided
   Date of service
   Place of service
   Amount charged for each service
   Diagnosis code
   Procedure code
   **Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills*

4. Sign and date the Claim Form.

5. Verify all information and submit this form along with the copy of your itemized bill to:

   Peak Health
   1085 Van Voorhis Rd, Suite 300
   Morgantown, WV 26505

6. Missing information can result in a delay on non-payment of the claim. Please be sure the information is clear and readable.

7. Have any questions or need help? Contact Member Service at 1-833-5-MYPEAK (1-833-569-7325) or visit www.peakhealth.org.